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ALDARA® / IMIQUIMOD CREAM 5%

Drug Class: Dermatological - Immunomodulator - Imidazoquinolinamines

FDA-approved uses:

- ❒ **Actinic Keratosis:** Imiquimod Cream is indicated for the topical treatment of clinically typical, nonhyperkeratotic, nonhypertrophic actinic keratoses on the face or scalp in immunocompetent adults.
- ❒ **Superficial Basal Cell Carcinoma:** Imiquimod Cream is indicated for the topical treatment of biopsy-confirmed, primary superficial basal cell carcinoma (sBCC) in immunocompetent adults, with a maximum tumor diameter of 2.0 cm, located on the trunk (excluding anogenital skin), neck, or extremities (excluding hands and feet), only when surgical methods are medically less appropriate and patient follow-up can be reasonably assured.
    - The histological diagnosis of superficial basal cell carcinoma should be established prior to treatment, since safety and efficacy of Imiquimod Cream have not been established for other types of basal cell carcinomas, including nodular and morpheaform (fibrosing or sclerosing) types.
- ❒ **External Genital Warts:** Imiquimod Cream is indicated for the treatment of external genital and perianal warts/condyloma acuminata in patients 12 years old or older.

Available dosage forms: Cream, 5%, supplied in single-use packets containing 250 mg of the cream.

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:**
    - Actinic keratosis **OR**
    - Superficial basal cell carcinoma **OR**
    - External genital warts
- ❒ **Duration of Approval:**
    - **Initial Authorization:** 16 weeks
    - **Continuation of Therapy:** 16 weeks
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - An inadequate response or intolerance to office-based treatments **OR** have been considered and ruled out as options due to the nature/number of lesions or limited resources to provide such treatments

      Actinic Keratosis, Superficial Basal Cell Carcinoma
        - An inadequate response to a full treatment course or intolerance/contraindication to a trial of a covered 5-fluorouracil product

      External genital warts
        - Intolerance/contraindication (i.e. pregnancy) to a trial of podofilox solution
- ❒ **Quantity:** 48 units per 16 weeks
- ❒ **Age:** 12 years of age and older
- ❒ **Route of Administration:** Topical

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - There is a recurrence of active lesions and treatment with another course of therapy is required

Contraindications/Exclusions/Discontinuation:

- Cosmetic purposes
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

AMPYRA® / DALFAMPRIDINE

Drug Class: Multiple Sclerosis Agent – Potassium Channel Blocker

FDA-approved uses: Indicated as a treatment to improve walking in patients with multiple sclerosis (MS).

Available dosage forms: 10 mg Extended-Release Tablet

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:** Documented diagnosis of multiple sclerosis with impaired walking ability
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:** Prescribed by a neurologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient must not be wheelchair-bound
  - Patient must not have a history of seizures
  - Patient must not have moderate to severe renal impairment (Crcl < 50 ml/min)
  - Patient must be on disease modifying therapy for MS/confirmed diagnosis of MS
  - Documentation of significant and continuous walking impairment that impairs ability to complete normal activities of daily living (such as meal preparation, household chores, etc.) attributable to ambulation or functional status despite optimal treatment for Multiple Sclerosis
  - And, Baseline 25-ft walking test between 8 and 45 seconds
    OR
  - Member is ambulatory***** AND has an Expanded Disability Status Scale (EDSS)****** score **greater than or equal to 4.5 but less than 7**
    **Does not require the use of a wheelchair (bilateral assistance is acceptable, such as a brace, cane, or crutch, as long as the patient can walk 20 meters without resting)*

    ***The Expanded Disability Status Score (EDSS) quantifies disability in eight functional systems: pyramidal, cerebellar, brainstem, sensory, bowel and bladder, visual, cerebral, and other. EDSS scores 1.0 to 4.5 refer to people with multiple sclerosis who are fully ambulatory. EDSS scores 5.0 to 9.5 are defined by increasing impairment to ambulation.*
- ❒ **Age:** Patient is between 18 and 70 years old
- ❒ **Route of Administration:** Oral

Criteria for continuation of therapy

❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):

- Member currently meets ALL initial coverage criteria confirmed by documentation
- Adherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history
- Functional impairment resolved as a result of increased speed of ambulation resulting in the member being able to complete instrumental activities of daily living (such as meal preparation, household chores, etc.)
  AND
- Requires: **At least 20% improvement in timed walking speeds on 25-ft walk within 4 weeks)**
  OR
- Improvement of at least 20% in timed walking speed as documented by the T25FW (timed 25-foot walk) from pre-treatment baseline:

Contraindications/Exclusions/Discontinuation:

- Patient does NOT have a diagnosis of spinal cord injury, myasthenia gravis, demyelinating peripheral neuropathies (such as Guillain-Barré syndrome), Alzheimer's disease, and Lambert Eaton myasthenic syndrome.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

ARIXTRA® / FONDAPARINUX

Drug Class: Indirect Factor Xa Inhibitors

FDA-approved uses:

- ❒ Prophylaxis of Deep Vein Thrombosis (DVT) which may lead to pulmonary embolism (PE):
  - in patients undergoing hip fracture surgery, including extended prophylaxis
  - in patients undergoing hip replacement surgery
  - in patients undergoing knee replacement surgery
  - in patients undergoing abdominal surgery who are at risk for thromboembolic complications.
- ❒ Treatment of Acute Deep Vein Thrombosis when administered in conjunction with warfarin sodium
- ❒ Treatment of Acute Pulmonary Embolism when administered in conjunction with warfarin sodium when initial therapy is administered in the hospital.

Available dosage forms: Single-dose, prefilled syringes containing either 2.5 mg, 5 mg, 7.5 mg, or 10 mg of fondaparinux

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA approved indication detailed above
- ❒ **Duration of Approval:**
  - **Initial Authorization:** Usual duration of administration is 5 – 9 days; and up to 11 days administration has been tolerated for DVT prophylaxis; and up to 26 days have been administered for DVT and PE treatment
  - **Continuation of Therapy:** Length of renewal authorization based on anticipated length of therapy, indication and/or recent INR if on warfarin
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Date of surgery or diagnosis of VTE
  - Documentation of adequate trial and failure of preferred formulary agent or contraindication to preferred formulary agent
    - Approved for patients with a history of heparin-induced thrombocytopenia who require anticoagulation
- ❒ **Quantity:**
  - **Prophylaxis (post knee or hip surgery):** Up to 35 days
  - **Prophylaxis (abdominal surgery):** Up to 14 days
  - **VTE treatment, bridge therapy, acute illness:** 10 days or as requested
  - **High risk pregnancy:** Until 6 weeks after delivery (EDC required for authorization)
  - **Upper extremity DVT:** 3 months
  - **Lower-limb SVT:** 45 days
- ❒ **Age:** Greater than 17 years of age
- ❒ **Gender:** Male or Female
- ❒ **Route of Administration:** Subcutaneous
- ❒ **Place of Service:** Outpatient

Use of subcutaneous (SQ) unfractionated heparin (UFH) is required in prophylaxis in high-risk pregnancy

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - INR
  - Medical Record
  - Detailed rationale for continued treatment beyond recommended duration

Contraindications/Exclusions/Discontinuation:

- Severe renal impairment (CrCl < 30ml/min)
- Body weight of < 50 kg
- Active major bleeding or bacterial endocarditis
- Thrombocytopenia associated with positive in vitro test for anti-platelet antibody in the presence of fondaparinux
- Known hypersensitivity to fondaparinux
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Caution in conditions with increased risk of hemorrhage
- Caution in patients treated concomitantly with platelet inhibitors
- Caution in patients with a history of heparin-induced thrombocytopenia
- Non-FDA approved indications recommended in CHEST guidelines:
  - Bridge therapy for perioperative warfarin discontinuation
  - Prophylaxis or treatment of thrombotic complications in a high risk pregnancy
  - VTE prophylaxis in patients with restricted mobility during acute illness
  - Treatment of superficial vein thrombosis (SVT) of the lower limb of at least 5 cm in length
  - Treatment of acute upper-extremity DVT (UEDVT) that involves the axillary or more proximal veins

AVONEX® / INTERFERON BETA 1A

Drug Class: interferons, Multiple Sclerosis modifying agents

FDA-approved uses: **Multiple sclerosis-** Treatment of relapsing forms of multiple sclerosis (MS) to decrease the frequency of clinical exacerbations and delay the accumulation of physical disability.

Available dosage forms: *Vial 30 mcg Admin Pack, *Prefilled Syringe 30 mcg, *Prefilled Syringe 30 mcg Kit, *Pen Kit 30 mcg/0.5ml, Pen 30 mcg/0.5ml
**Covered on the Managed Care Common Formulary*

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Relapsing form of MS
- ❒ **Duration of therapy**:
  - **Initial Authorization:** 6 months
  - **Continuation of approval:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Diagnosis of a relapsing form of MS
- ❒ **Age restrictions**: > 18 years of age.
- ❒ **Prescriber Specialty**: Neurologist

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Requires certification from a neurologist that therapy has been effective, i.e. treatment has decreased relapses or diminished number of lesions on MRI

Contraindication/Exclusion/Discontinuation:

- **Hypersensitivity reactions:** Allergic reactions, including anaphylaxis, have been reported. Some reactions may occur after prolonged use. Discontinue therapy if anaphylaxis or other allergic reactions occur
- Hypersensitivity to natural or recombinant interferon beta, human albumin (albumin-containing formulations only), or any other component of the formulation.
- **Autoimmune disorder development:** Consider discontinuing treatment. This can include bone marrow suppression with pancytopenia, leukopenia, and thrombocytopenia.
- **Depression or other severe psychiatric symptoms:** Consider discontinuing treatment

Contraindication/Exclusion/Discontinuation, continued

- **Hepatotoxicity:**
    - **ALT more than 5 × ULN:** Temporarily discontinue therapy or consider dose reduction until ALT normalizes, then may consider re-titration of dose.
    - **Symptomatic (e.g., jaundice):** Discontinue immediately.
    - **Leukopenia:** May require temporary discontinuation or dose reduction until resolution.
    - **Albumin:** Some formulations contain albumin, which may carry a remote risk of transmitting Creutzfeldt-Jakob or other viral diseases. Interferon beta-1a formulations that contain albumin are contraindicated in albumin-sensitive patients.
- **Injection-site reactions:** Severe injection-site reactions have occurred, including pain, erythema, edema, cellulitis, abscess, and necrosis. Necrosis may occur at single and multiple sites. Some reactions have occurred 2 or more years after initiation; reactions typically resolve with conservative treatment (antibiotics or surgical intervention may be required). Patient and/or caregiver competency in injection technique should be confirmed and periodically reevaluated.
- **Cardiovascular disease:** Use with caution in patients with preexisting cardiovascular disease. Rare cases of new-onset cardiomyopathy and/or heart failure have been reported.
- **Thyroid dysfunction:** Thyroid abnormalities may develop with use; may worsen preexisting thyroid conditions. Monitor thyroid function tests every 6 months or as clinically necessary.
- **Thrombotic microangiopathy:** Cases of thrombotic microangiopathy manifesting as thrombotic thrombocytopenic purpura (TTP) or hemolytic uremic syndrome (HUS) (some fatal) have been reported.[12] [13] Some cases may occur after several years of therapy. Monitor for new-onset hypertension, thrombocytopenia, or impaired renal function; discontinuation of therapy and prompt treatment may be necessary if TTP/HUS are confirmed.
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Analgesics and/or antipyretics may help decrease flu-like symptoms on treatment days.
- **Chronic progressive multiple sclerosis:** Safety and efficacy have not been established for this use.
- **Latex:** The packaging (prefilled syringe tip cap) may contain latex

CAYSTON® / AZTREONAM

Drug Class: Monobactam Antibacterial

FDA-approved uses: To improve respiratory symptoms in cystic fibrosis patients with *Pseudomonas aeruginosa*

Available dosage forms: 75mg Powder for Inhalation Solution

Coverage Criteria/Limitations for initial authorization

- **Diagnoses:** Patient must have Cystic Fibrosis confirmed by appropriate diagnostic or genetic testing
- **Duration of Approval**: Used 28 days, followed by 28 days off
  - **Initial Authorization:** 6 months
  - **Continuation of Therapy:** Re-authorization for continuation of treatment is required every 6 months to determine continued need based on documented positive clinical response

❒ **Prescriber Specialty:** Prescribed by or in consultation with a pulmonologist or specialist with experience in treating Cystic Fibrosis**.**

❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):

- Patient must have Cystic Fibrosis confirmed by appropriate diagnostic or genetic testing
- Patient must be using bronchodilators which are administered prior to aztreonam.
- Confirmation of ***Pseudomonas aeruginosa*** in cultures of the airways confirmed by a copy of a positive sputum culture
- Susceptibility results indicating that aztreoman is the only inhaled antibiotic to which the Pseudomonas aeruginosa is sensitive

  OR

  At least **ONE** of the following is applicable. Documentation required:
  - Previously use of TOBI® inhalation solution and experienced a clinically significant adverse drug reaction or an unsatisfactory therapeutic response
  - Contraindication/intolerance or medical condition(s) that prevents the use of TOBI® inhalation solution (e.g., patient is pregnant, allergy to tobramycin)
  - Sputum culture shows resistance to tobramycin
  - Confirmation that member is not receiving treatment with other inhaled/nebulized antibiotics or inhaled/nebulized anti-infective agents, including alternating treatment schedules or as part of a cyclic rotation with TOBI®

❒ **Age:** 7 years or older

❒ **Route of Administration:** Inhalation

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Cayston (aztreonam) may be authorized for continuation of therapy if **ALL** of the following criteria are met:
    - Member currently meets **ALL** initial coverage criteria
    - Adherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history (review Rx history for compliance),
    - Documentation of **stabilization or improvement** as evaluated by a pulmonologist or specialist with experience in treating cystic fibrosis

Contraindications/Exclusions/Discontinuation:

- Less than 7 years of age
- FEV1 less than 25% or greater than 75% predicted
- Colonization with Burkholderia cepacia
- Non-FDA approved indications
- Hypersensitivity to aztreonam or any of its components
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations: Administer only with the Altera Nebulizer system

CELEBREX® / CELECOXIB

Drug Class: COX-2 selective inhibitors

FDA-approved uses:

- ❒ Acute pain in adults
- ❒ Ankylosing spondylitis
- ❒ Juvenile rheumatoid arthritis (ages 2 and older)
- ❒ Osteoarthritis
- ❒ Primary dysmenorrhea
- ❒ Rheumatoid arthritis

Available dosage forms: Oral Capsule, 50mg, 100mg, 200mg & 400mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA approved indications detailed above
- ❒ **Duration of Approval:**
  - **Initial Authorization**: 60 days to assure a response
  - **Continuation of Therapy:** 1 year –Use the lowest effective dose for the shortest duration consistent with individual patient treatment goals.
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient must have failed two non-selective NSAIDs **OR**
  - Patient has failed on a non-selective NSAID used with Cytotec or a PPI**, OR**
  - Patient has a history of a GI Bleed , obstruction, perforation or peptic ulcer, **OR**
  - Patient is at risk for a GI Bleed (e.g. taking anticoagulants or systemic steroids. **OR**
  - Patient has a diagnosis of Familial Adenomatous Polyposis (FAP)
- ❒ **Age:**
  - **Younger than 2 years*:*** Not studied in patients younger than 2 years
  - **Adults and children 2 years and older:** There are no well-established maximum doses for the approved indications according to the prescribing information.
  - **Elderly:** Dose adjustment is not generally necessary. However, for patients weighing less than 50 kg, initiate therapy at the lowest recommended dose
- ❒ **Route of Administration:** Oral

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Patient must have a chronic pain condition of the following and have responded to the initial use of Celebrex without complications:
    - Ankylosing spondylitis
    - Juvenile rheumatoid arthritis (ages 2 and older)
    - Osteoarthritis
    - Primary dysmenorrhea
    - Rheumatoid arthritis

Contraindications/Exclusions/Discontinuation:

- **Cardiovascular risk:**
  - Celecoxib may cause an increased risk of serious cardiovascular thrombotic events, myocardial infarction (MI), and stroke, which can be fatal. All nonsteroidal anti-inflammatory drugs (NSAIDs) may have a similar risk. This risk may increase with duration of use. Patients with cardiovascular disease or risk factors for cardiovascular disease may be at higher risk.
  - Celecoxib is contraindicated for the treatment of perioperative pain in the setting of coronary artery bypass graft (CABG) surgery.
- **GI risk:**
  - NSAIDs, including celecoxib, cause an increased risk of serious GI adverse events, including bleeding, ulceration, and perforation of the stomach or intestines, which can be fatal. These events can occur at any time during use and without warning symptoms. Elderly patients are at higher risk for serious GI events.
- **Renal function impairment:**
  - Not recommended in patients with severe renal impairment.[1]
- **Hepatic function impairment:**
  - ***Moderate hepatic impairment (Child-Pugh class B):*** Reduce daily dose by approximately 50%.[1]
  - ***Severe hepatic impairment:*** Use is not recommended.
- **Poor metabolizers of CYP2C9:**
  - Use with caution. Consider starting treatment at half the lowest recommended dose. Consider using alternate management in juvenile RA patients who are poor metabolizers
- Hypersensitivity to celecoxib, sulfonamides, aspirin, other NSAIDs, or any component of the formulation; patients who have demonstrated allergic-type reactions to sulfonamides; patients who have experienced asthma, urticaria, or allergic-type reactions after taking aspirin or other NSAIDs.
- Health plan may discontinue therapy if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

CLARAVIS® / ISOTRETINOIN

Drug Class: Acne Therapy Systemic - Retinoids & Derivatives

FDA-approved uses: Treatment of severe (multiple locations) recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics

Available dosage forms: Capsule 10 mg, 20 mg, 30 mg, and 40 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** severe (multiple locations) recalcitrant nodular acne unresponsive to conventional therapy including conventional antibiotics
- ❒ **Duration of Approval**
  - **Initial Authorization:** 5 months, with monthly office visits
  - **Continuation of Therapy:** Reviewed for coverage after a period of 2 months or more off therapy, and if warranted by persistent or recurring severe nodular acne
- ❒ **Prescriber Specialty:** Dermatologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Proper diagnosis of an FDA approved indication **OR**
  - If request is for a non-FDA Approved indication, the request must be for a "medically accepted indication" as noted in the following Compendia:
    - American Hospital Formulary Drug Service (AHFS-DI)
    - Micromedex DrugDex
    - Clinical Pharmacology
  - Must be prescribed by a dermatologist
  - Current chart notes detailing the diagnosis, including laboratory tests as appropriate for diagnosis
  - Documentation of dose, dates of therapy, and clinical outcomes as appropriate
  - Failed/intolerant to at least 2 oral antibiotics (must have used consistently for 6 months)
  - Failed/intolerant to topical Retin-A (must have used consistently for 6 months)
  - Failed/intolerant to Benzoyl Peroxide wash (must have used consistently for 6 months)
  - Failed/intolerant to Clindamycin and/or Erythromycin topical therapy (must have used consistently for 6 months)
  - Negative pregnancy test
  - Must select 2 forms of effective contraception simultaneously
  - Must meet requirements of the iPledge Program
- ❒ **Not approved If:**
  - Patient has any contraindications to the use of isotretinoin
  - Patient is not compliant with current therapy

- ❒ **Dosing:**
  - ***Adult Acne, severe recalcitrant nodular:***
    - Oral: 0.5-1 mg/kg/day in 2 divided doses for 15-20 weeks
    - May discontinue earlier if the total cyst count decreases by 70%
    - Adults with very severe disease/scarring or primarily involves the trunk may require dosage adjustment up to 2 mg/kg/day
    - A second course of therapy may be initiated after a period of ≥ 2 months off therapy
    - A dose of ≤0.5 mg/kg/day may be used to minimize initial flaring
  - ***Pediatric Acne, severe recalcitrant nodular:***
    - Children 12-17 years:
      - Oral: 0.5-1 mg/kg/day in 2 divided doses for 15-20 weeks
      - May discontinue earlier if the total cyst count decreases by 70%
      - A second course of therapy may be initiated after a period of ≥ 2 months off therapy
      - A dose of ≤0.5 mg/kg/day may be used to minimize initial flaring
- ❒ **Age:** 12 years and older
- ❒ **Route of Administration:** Oral

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Office visit every month with verified compliance and improvement or stability on drug

Contraindications/Exclusions/Discontinuation:

- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable of improvement in clinical condition has occurred after initiation of drug therapy

References:

a. American Academy of Pediatrics Committee on Drugs, "Retinoid Therapy for Severe Dermatological Disorders," *Pediatrics*, 1992, 90(1 Pt 1):119-20.
b. Claravis [package insert]. Sellersville PA: Teva Pharmaceuticals USA; January 2015.
c. Facts & Comparisons. (2012). Claravis. Retrieved from http://0-online.factsandcomparisons.com.libcat.ferris.edu/MonoDisp.aspx?monoID=fandc-hcp1943&quick=159351%7c5&search=159351%7c5&isstemmed=True.
d. Mitchell AA, Van Bennekom CM, Louik C, et al, "A Pregnancy-Prevention Program in Women of Childbearing Age Receiving Isotretinoin," *N Engl J Med*, 1995, 333(2):101-6.
e. iPledge. (2015). Claravis iPledge Program. www.ipledgeprogram.com
f. Graber E, et al "Treatment of Acne Vulgaris," *UptoDate,* November, 10, 2015.

DARAPRIM® / PYRIMETHAMINE

Drug Class: Antimalarials

FDA-approved uses:

- ❒ Treatment of toxoplasmosis: Daraprim is indicated for the treatment of toxoplasmosis when used conjointly with a sulfonamide.
- ❒ Treatment of acute Malaria: Daraprim is indicated for the treatment of acute malaria. It should not be used alone to treat acute malaria. Fast-acting schizonticides such as chloroquine or quinine are indicated and preferable for the treatment of acute malaria. However, conjoint use of Daraprim with a sulfonamide will initiate transmission control and suppression of susceptible strains of plasmodia.
- ❒ Malaria prophylaxis: Daraprim is indicated for the chemoprophylaxis of malaria due to susceptible strains of plasmodia. However, resistance to pyrimethamine is prevalent worldwide. It is not suitable as a prophylactic agent for travelers to most areas.

Available dosage forms: 25mg Tablet

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:**
  - Treatment of Toxoplasmosis
  - Secondary prevention of Toxoplasmosis in patients with HIV
  - Prevention of pneumocystis pneumonia in patients with HIV
- ❒ **Duration of Approval:**
  - **Initial Authorization:**
    - Toxoplasmosis – 6 weeks
    - Pneumocystis prophylaxis – 3 months
  - **Continuation of Therapy:**
    - Toxoplasmosis – 6 months
    - Pneumocystis – 3 months
- ❒ **Prescriber Specialty**: infectious disease
- ❒ **Documentation Requirements:** (e.g. Labs, Medical Record, Special Studies):
  - For Pneumocystis diagnosis ONLY: TMP/SMX, atovaquone, and dapsone
  - For Pneumocystis prophylaxis (ONE of the following):
    - CD4 count <200 cells/microL
    - Oropharyngeal candidiasis
    - CD4 count percentage <14 percent
    - CD4 cell count between 200 and 250 cells/microL IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

- ❒ **Quantity:**
  - Toxoplasmosis (induction-dose): 90 tablets per 30 days
  - Toxoplasmosis (maintenance-dose): 60 tablets per 30 days
  - Pneumocystis prophylaxis: 12 tablets per 28 days
- ❒ **Gender:** male and female
- ❒ **Route of Administration:** oral
- ❒ **Place of Service:** outpatient

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - For Toxoplasmosis prophylaxis, after initial 6 weeks of induction treatment (ONE of the following):
    - Patient remains symptomatic
    - Patient is NOT receiving antiretroviral therapy (ART)
    - Patient has a detectable HIV viral load
    - Patient has maintained a CD4 count >200 cells/microL for less than six months
  - For Pneumocystis prophylaxis (ONE of the following):
    - CD4 count <200 cells/microL
    - Oropharyngeal candidiasis
    - CD4 count percentage <14 percent
    - CD4 cell count between 200 and 250 cells/microL IF frequent monitoring (eg, every three months) of CD4 cell counts is not possible

Contraindications/Exclusions/Discontinuation:

- Megaloblastic anemia due to folate deficiency
- Secondary prophylaxis of Toxoplasmosis in patients with a CD4 count >200 cells/microL for longer than 6 months and a sustained HIV viral load
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Daraprim is no longer recommended for malaria treatment or prophylaxis and treatment of malaria is very individualized.
- Refer to the CDC website for recommendations for treatment and prevention of malaria.

References

1. Gandhi RT. Toxoplasmosis in HIV-infected patients. Waltham, MA: UptoDate; Last modified September 21, 2015. http://www.uptodate.com/contents/toxoplasmosis-in-hiv-infected-patients?source=search_result&search=daraprim&selectedTitle=6%7E47. Accessed September 25, 2015.

References, continued

2. Thomas CF, Limper AH. Treatment and prevention of Pneumocystis pneumonia in non-HIV-infected patients. Waltham, MA: UptoDate; Last modified January 6, 2015. http://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-pneumonia-in-non-hiv-infected-patients?source=search_result&search=pneumocystis&selectedTitle=4%7E150. Accessed September 25, 2015.
3. Sax PE. Treatment and prevention of Pneumocystis infection in HIV-infected patients. Waltham, MA: UptoDate; Last modified August 27, 2015. http://www.uptodate.com/contents/treatment-and-prevention-of-pneumocystis-infection-in-hiv-infected-patients?source=search_result&search=pneumocystis&selectedTitle=2%7E150#H2384560994. Accessed September 25, 2015.

DDAVP / DESMOPRESSIN / STIMATE

Drug Class: Antidiuretic and vasopressor hormones

FDA-approved uses:

- ❒ Hemophilia A - Stimate only
- ❒ von Willebrands disease type I - Stimate only
- ❒ Diabetes Insipidus - Desmopressin only
- ❒ Enuresis - Desmopressin only

Available dosage forms:

- ❒ Desmopressin – 0.1 mg/ml solution, 10 mcg/0.1 ml spray
- ❒ Stimate – 150 mcg/spray (0.1ml)

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses**:
  - Hemophilia
  - von Willebrands disease
  - Diabetes Insipidus
  - Enuresis
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documentation of any of the following diagnoses:
    - Enuresis
    - Diabetes insipidus
    - Hemophilia
    - von Willebrands disease (Type 1)
  - Documented trial of enuresis alarm system is required for a diagnosis of enuresis
- ❒ **Route of Administration:** various

Contraindications/Exclusions/Discontinuation:

- Contraindicated in individuals with known hypersensitivity to desmopressin acetate or to any of its components.
- Contraindicated in patients with moderate to severe renal impairment (defined as a creatinine clearance below 50ml/min).
- Contraindicated in patients with hyponatremia or a history of hyponatremia.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

DOVONEX® / CALCIPOTRIENE

Drug Class: Dermatological - Antipsoriatics

FDA-approved uses: The relief of Psoriasis

Available dosage forms: 0.005% Cream, Ointment and Solution

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:** Psoriasis
- ❒ **Duration of Approval**
  - **Initial Authorization:** 3 months
  - **Continuation of Therapy:** 6 months
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Diagnosis of Psoriasis
  - Failure of two Topical Steroids, at least one of which must be high potency or very high potency
- ❒ **Route of Administration:** For Topical Use Only

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Requires a positive response to therapy

Contraindications/Exclusions/Discontinuation:

Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy

DPP-4 INHIBITORS
JANUVIA® / SITAGLIPTIN
TRADJENTA® / LINAGLIPTIN
COMBINATION DPP-4 INHIBITORS
JANUMET® / SITAGLIPTIN-METFORMIN
JANUMET XR® / SITAGLIPTIN-METFORMIN
JENTADUETO® / LINAGLIPTIN-METFORMIN

Drug Class: Antihyperglycemic – Dipeptidyl Peptidase-4 (DPP-4) Inhibitor & Biguanide

FDA-approved uses:

Single Ingredient DPP-4 Inhibitor

Type 2 diabetes mellitus: Treatment of type 2 diabetes mellitus (noninsulin dependent) as an adjunct to diet and exercise to improve glycemic control

Combination DPP-4 Inhibitor

Type 2 diabetes mellitus: As an adjunct to diet and exercise to improve glycemic control in adults with Type 2 diabetes mellitus when treatment with both sitagliptin and metformin is appropriate

Available dosage forms:

Single Ingredient Products

- ❒ Januvia Tablet 25 mg, 50 mg, 100 mg
- ❒ Tradjenta Tablet 5 mg

Combination Ingredient Products

- ❒ Janumet Tablet 50/500, 50/1000
- ❒ Janumet XR Tablet 50/500, 50/1000, 100/1000
- ❒ Jentadueto Tablet 2.5 mg-500 mg, 2.5 mg-850 mg, 2.5 mg-1000 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA Approved Indication as listed above
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Therapy:** 6 months

Single Ingredient DPP-4 Inhibitor

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Tried and failed Metformin
  - A1c must be less than or equal to 9
- ❒ **Age:** ≥ 18 years of age

Combination DPP-4 Inhibitor

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Clinically demonstrated successful treatment with individual components for 60 of the most recent 120 days
  - A1c must be less than or equal to 9
- ❒ **Age:** ≥ 18 years of age

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient responding to treatment
  - Patient tolerating treatment

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

DURAGESIC® TRANSDERMAL PATCH / FENTANYL TRANSDERMAL

Drug Class: Analgesic Narcotic Agonists

FDA-approved uses: Chronic pain: Management of pain in opioid-tolerant patients 2 years and older severe enough to require daily, around-the-clock opioid treatment and for which alternative treatment options are inadequate.

Opioid-tolerant patients are defined as patients who are taking at least 60 mg/day of oral morphine, or 25 mcg/hour of transdermal fentanyl, or 30 mg/day of oral oxycodone, or 8 mg/day of oral hydromorphone, or 25 mg/day of oral oxymorphone, or equianalgesic dose of another opioid for at least 1 week.[1]

Available dosage forms:

- ❒ Fentanyl transdermal patches of the following doses: 12mcg/HR, 25 mcg/HR, 37.5 mcg/HR, 50 mcg/HR, 62.5 mcg/HR, 75 mcg/HR, 87.5 mcg/HR, 100 mcg/HR

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA approved indication detailed above
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 90 days
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:** Board-certified pain management physician
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Chronic pain condition must be present and documented
  - Tried and failed one other long acting opioid analgesic on the Common Formulary
  - The medication is intended for regular, round the clock use, not PRN
  - Based on the patient's narcotic history, the use of this medication is deemed safe
- ❒ **Quantity:** #10 at initiation, may be increased if needed dose exceeds 100 mcg post dose titration.
- ❒ **Age:** > 2 years old
- ❒ **Route of Administration:** Transdermal

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Criteria for initial authorization continues
  - Patient is responsive to treatment

Contraindications/Exclusions/Discontinuation:

- **Fentanyl patches are not intended for use when the following situations are present:**
  - Significant respiratory depression, especially in unmonitored settings
  - Acute or severe bronchial asthma
  - Current or suspected paralytic ileus
  - Known hypersensitivity to fentanyl or any components of Duragesic
  - Management of acute pain or in patients who require opioid analgesia for a short period of time
  - Management of post-operative pain, including use after out-patient or day surgeries (e.g., tonsillectomies)
  - Management of mild pain
  - Management of intermittent pain (e.g., use on an as needed basis [PRN])
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- **Limitations of use:** Because of the risks of addiction, abuse, and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release (ER) opioid formulations, reserve fentanyl for use in patients for whom alternative treatment options (e.g., non-opioid analgesics, immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain.

ELIDEL® / PIMECROLIMUS

Drug Class: Dermatological – Calcineurin Inhibitors

FDA-approved uses: Atopic dermatitis: Second-line therapy for short-term and non-continuous long-term treatment of mild to moderate atopic dermatitis in non-immunocompromised patients 2 years and older who have failed to respond adequately to other topical prescription treatments, or when those treatments are not advisable

Available dosage forms: 1% cream, applied twice a day

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** atopic dermatitis (a type of eczema)
- ❒ **Duration of Approval:**
  - **Initial Approval:** Reassess after 6 weeks of treatment (Avoid continuous, long-term use of pimecrolimus. If signs and symptoms persist longer than 6 weeks, patients should be reexamined to confirm the diagnosis of atopic dermatitis)
  - **Continuation of Therapy:** 6 weeks to 3 months
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Tried and failed topical moisturizers or emollients
  - Oral / systemic medications such as antihistamines (first or second generation) and antipruritics (ex. hydroxyzine)
  - Avoidance of triggers due to diet, irritants (soaps, detergents, etc.), fabrics
  - Tried and failed at least two topical steroids, to include up to a medium strength product **OR**
  - a clinical reason why treatment with a moderate to high potency topical steroid is not appropriate (e.g. inadequate response, skin atrophy, or use on an area of the body at high risk for skin atrophy, such as the face or skin folds)
  - Note areas of involvement (face, trunk, back, etc.) and % of body involved
- ❒ **Age:** 2 years of age or older -- Not indicated for use in children younger than 2 years
- ❒ **Route of Administration:** Topical

Criteria for continuation of therapy: (Beyond 3 months total is not recommended)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Consultation with a specialist

Contraindications/Exclusions/Discontinuation:

- Not for chronic use
- Elidel® is not recommended for use on patients with Netherton's syndrome due to the potential for systemic absorption.
- Not recommended (especially Elidel®) for use in immunocompromised patients
- Should not be applied to infected skin whether bacterial, viral, or fungal.
- Although a causal relationship has not been established, rare cases of malignancy (e.g., skin malignancy, lymphoma) have been reported in patients treated with topical calcineurin inhibitors, including pimecrolimus. Therefore, avoid continuous, long-term use of topical calcineurin inhibitors, including pimecrolimus, in any age group, and limit application to areas of involvement with atopic dermatitis.
- Pimecrolimus is not indicated for use in children younger than 2 years.
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Off-label use for the following have been reported:
    - Lichen planus (oral)
    - Psoriasis
    - Rosacea
    - Vitiligo

ELMIRON® / PENTOSAN POLYSULFATE SODIUM

Drug Class: Urinary tract analgesic agents

FDA-approved uses: indicated for the relief of bladder pain or discomfort associated with interstitial cystitis.

Available dosage forms: 100mg Capsules

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses**: interstitial cystitis
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Diagnosis of interstitial cystitis confirmed

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

ENBREL® / ETANERCEPT

Drug Class: Anti-inflammatory Tumor Necrosis Factor Inhibiting agents, Non-Selective

FDA-approved uses:

- ❒ Ankylosing spondylitis
- ❒ Plaque psoriasis
- ❒ Polyarticular juvenile idiopathic arthritis (JIA) – for 2 years of age or older
- ❒ Psoriatic arthritis
- ❒ Rheumatoid arthritis

Available dosage forms: 25 mg subcutaneous kit; 25mg/0.5ml and 50mg/ml subcutaneous solution, prefilled syringes, Enbrel 50mg/ml Sure Click, a subcutaneous solution auto-injector

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA approved indications detailed above
- ❒ **Duration of Approval:**
  - **Initial Authorization:**
    - **Enbrel 50mg twice weekly**: 3 months
    - Dose for plaque psoriasis should be reduced to 50mg per week after the initial 3 month approval
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:** Rheumatologist, dermatologist, or provider in consultation with specialist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documentation of a current negative TB test
  - **Additional criteria based on the diagnosis** (unless contraindications are documented):
    - **Ankylosing Spondylitis** (Enbrel):
      - Trial and failure of 2 different NSAIDs within the last 60 days
      - Trial and failure of sulfasalazine
      - Age restriction: must be at least 18 years old
    - **Plaque Psoriasis** (Enbrel):
      - Clinically diagnosed with moderate to severe chronic plaque psoriasis
      - Involvement of greater than 15% of body surface area (unless hands, feet, head, neck, or genitalia are involved)
      - Trial and failure of at least one topical agent
      - Trial and failure of at least two systemic treatments (azathioprine, cyclosporine)
      - Trial and failure of UVB or PUVA therapy or contraindication to therapy
      - Trial and failure of methotrexate for at least 3 consecutive months or contraindication/intolerance to methotrexate

- ❒ **Documentation Requirements, continued** (e.g. Labs, Medical Record, Special Studies):
    - **Psoriatic Arthritis:**
        - Trial and failure of one additional DMARD
        - Trial and failure of methotrexate for at least 3 months
        - Age restriction: must be at least 18 years old
    - **Rheumatoid Arthritis** (Adults):
        - Trial and failure of methotrexate and at least 1 other oral DMARD (sulfasalazine, hydroxychloroquine or leflunomide) as sequential monotherapy for 3 months each or in combination for at least 3 months (or contraindication/intolerance to methotrexate and other DMARDs)
    - **JIA** (age ≥ 2 years for Enbrel):
        - Trial and failure of at least 3 consecutive months of methotrexate or contraindication/intolerance to methotrexate
- ❒ **Age:** 18 years of age or older, except for JIA (>2 years of age)
- ❒ **Route of Administration:** Subcutaneous

Criteria for continuation of therapy:

- ❒ **Documentation Requirements:**
    - All criteria present for initiation of treatment continue to be met
    - Patient is compliant
    - Requires a response to therapy

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

ERYTHROPOIESIS STIMULATING AGENTS

ARANESP® / DARBEPOETIN ALFA
EPOGEN® / EPOETIN ALFA
PROCRIT® / EPOETIN ALFA

Drug Class: Erythropoietins (Aranesp); Erythropoiesis-Stimulating Agents (Epogen & Procrit)

FDA-approved uses:

- ❒ **Aranesp:** Anemia due to chronic kidney disease or chemotherapy in patients with cancer
- ❒ **Epogen & Procrit:**
  - Anemia due to the following:
    - Chronic kidney disease
    - Chemotherapy in patients with cancer
    - Anemia caused by zidovudine in HIV-infected patients
    - Reduction of allogeneic RBC transfusion in patients undergoing elective, non-cardiac, non-vascular surgery

Available dosage forms:

- ❒ **Aranesp:**
  - Vials of 25 mcg/ml, 40 mcg/ml, 60 mcg/ml, 100 mcg/ml, 150 mcg/0.75ml, 200 mcg/ml, 300 mcg/ml
  - Syringes of 10 mcg/0.4 ml, 25 mcg/0.42 ml, 40 mcg/0.4 ml, 60 mcg/0.3 ml, 100 mcg/0.5 ml, 150 mcg/0.3 ml, 200 mcg/0.4 ml, 300 mcg/0.6 ml, 500 mcg/1 ml
- ❒ **Epogen:**
  - Vials of 2,000 units/ml, 3,000 units/ml, 4,000 units/ml, 10,000 units/ml, 20,000 units/ml
- ❒ **Procrit:**
  - Vials of 2,000 units/ml, 3,000 units/ml, 4,000 units/ml, 10,000 units/ml, 20,000 units/ml, 40,000 units/ml

Aranesp

Coverage Criteria/Limitations for initial authorization:

Diagnosis: Anemia Due to CKD

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Hemoglobin < 10 g/dL within the last 2 weeks
  - Iron studies showing member has adequate iron stores to support erythropoiesis (e.g., ferritin >100, transferrin saturation >20%)

Aranesp, continued

Diagnosis: Anemia Due to Chemotherapy in Patients with Cancer

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient is currently receiving chemotherapy
  - Patient meets all of the following:
    - Hemoglobin < 10 g/dL within the 2 weeks prior to starting therapy
    - Documentation to support anemia is due to concomitant myelosuppressive chemotherapy
    - Diagnosis of non-myeloid malignancy (e.g., solid tumor)
    - Patient has a minimum of 2 additional months of planned chemotherapy upon initiation of therapy
  - Additional information may be required on a case-by-case basis to allow for adequate review.
- ❒ **Duration of approval:**
  - **Initial Authorization:** 3 months
  - **Continuation of therapy:** 3 months

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Approved diagnosis continues
  - Hb < 11 g/dL within the last 2 weeks
  - Follow up iron studies showing member has adequate iron to support erythropoiesis

Contraindications/Exclusions/Discontinuation:

- Anemia in patients with cancer who are not receiving chemotherapy
- Anemia associated with acute myelogenous leukemias (AML), chronic myelogenous leukemias (CML) or other myeloid cancers
- Anemia associated with radiotherapy (as monotherapy) in cancer
- To enhance athletic performance
- Substitute for red blood cell transfusions in patients who require immediate correction of anemia (i.e. acute blood loss)

Epogen & Procrit

Coverage Criteria/Limitations for initial authorization:

Diagnosis: Anemia Due to CKD

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Hemoglobin < 10 g/dL within the last 2 weeks
  - Iron studies showing member has adequate iron stores to support erythropoiesis (e.g., ferritin >100, transferrin saturation >20%)

Epogen & Procrit, continued

Diagnosis: Anemia Due to Chemotherapy in Patients with Cancer

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient is currently receiving chemotherapy
  - Patient meets all of the following:
    - Hemoglobin < 10 g/dL within the 2 weeks prior to starting therapy
    - Documentation to support anemia is due to concomitant myelosuppressive chemotherapy
    - Diagnosis of non-myeloid malignancy (e.g., solid tumor)
    - Patient has a minimum of 2 additional months of planned chemotherapy upon initiation of therapy

Diagnosis: Reduction of Allogeneic Red Blood Cell Transfusions in Patients Undergoing Elective, Non-cardiac, Non-vascular Surgery

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient will be undergoing elective, non-cardiac, non-vascular surgery
  - Hemoglobin level >10 and < 13 g/dL within 30 days prior to the planned surgery date

Diagnosis: Anemia due to Zidovudine in HIV-infected Patients

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient is receiving treatment with zidovudine at a dose < 4200 mg/week
  - Patient meets both of the following:
    - Endogenous erythropoietin levels < 500 mUnits/mL
    - Hemoglobin < 10 g/dL within the last two weeks
  - Additional information may be required on a case-by-case basis to allow for adequate review
- ❒ **Duration of approval:**
  - **Initial Authorization:** 3 months
    - **Exception- Reduction of perioperative RBC infusion:** Up to 21 days of therapy per surgery
  - **Continuation of therapy:** 3 months

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Approved diagnosis continues
  - Hb < 11 g/dL within the last 2 weeks
  - Follow up iron studies showing member has adequate iron to support erythropoiesis

Contraindications/Exclusions/Discontinuation:

- Anemia in patients with cancer who are not receiving chemotherapy
- Anemia associated with acute myelogenous leukemias (AML), chronic myelogenous leukemias (CML) or other myeloid cancers
- Anemia associated with radiotherapy (as monotherapy) in cancer
- To enhance athletic performance
- Substitute for red blood cell transfusions in patients who require immediate correction of anemia (i.e. acute blood loss)
- Uncontrolled hypertension; pure red cell aplasia (PRCA) that begins after treatment with epoetin alfa or other erythropoietin protein drugs; serious allergic reactions to epoetin alfa
- Increased mortality, myocardial infarction, stroke, and thromboembolism

FORTEO® / TERIPARATIDE (RECOMBINANT)

Drug Class: Bone formation Stimulating Agents – Parathyroid Hormone-Type

FDA-approved uses:

- ❒ **Glucocorticoid-induced osteoporosis**: Treatment of men and women with osteoporosis associated with sustained systemic glucocorticoid therapy (daily dosage equivalent to prednisone 5 mg or more) at high risk for fracture.
- ❒ **Osteoporosis in men:** To increase bone mass in men with primary or hypogonadal osteoporosis who are at high risk for fracture.
- ❒ **Osteoporosis in postmenopausal women:** Treatment of postmenopausal women with osteoporosis who are at high risk for fracture.

Off-label uses:

- ❒ **Treatment of hypoparathyroidism**

Available dosage forms: 600mcg/2.4 ml subcutaneous solution

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: ***For the treatment of Osteoporosis***
- ❒ **Duration of Approval:** Usual dosing is 20 mcg subcutaneously once daily.
  - **Initial Authorization**: ***Osteoporosis***-1 year, need baseline DEXA T-Score
  - **Continuation of Therapy**: ***Osteoporosis***-1 year, Use of teriparatide for more than 2 years is not recommended.
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - T-score less than or equal to -3 with a previous vertebral fracture **AND**
  - Documented failure of oral bisphosphonate despite compliance *(including new fracture or reduction in BMD per recent DEXA scan)* **OR**
  - Trial and failure to a compliant (at least 6 months) regimen or Intolerance of formulary medications used to treat osteoporosis (alendronate, Evista, Miacalcin [for vertebral fracture], Fortical nasal spray) **OR**
  - Trial and failure or Intolerance to a compliant (at least 12 months) regimen of Reclast
- ❒ **Age:** >18 years old, Safety and efficacy have not been established in pediatrics.
- ❒ **Route of Administration:** Subcutaneously

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - ***Osteoporosis***:
    - Continue to meet qualifying criteria.
    - Responding to treatment with evidence of maintenance or improved T-Score on DEXA scan.

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: ***For the treatment of Corticosteroid-induced Osteoporosis***
- ❒ **Duration of Approval:** Usual dosing is 20 mcg subcutaneously once daily.
  - **Initial Authorization**: ***Osteoporosis***-1 year, need baseline DEXA T-Score
  - **Continuation of Therapy**: ***Osteoporosis***-1 year, Use of teriparatide for more than 2 years is not recommended.
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - T-score less than or equal to -1 **AND**
  - Documented failure of oral bisphosphonate despite compliance *(including new fracture or reduction in BMD per recent DEXA scan).* **OR**
  - Trial and failure to a compliant (at least 6 months) regimen or Intolerance of formulary medications used to treat osteoporosis [alendronate, Evista, Miacalcin (for vertebral fracture), Fortical nasal spray] **OR**
  - Trial and failure or Intolerance to a compliant (at least 12 months) regimen of Reclast
- ❒ **Age:** >18 years old, Safety and efficacy have not been established in pediatrics.
- ❒ **Route of Administration:** Subcutaneously

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - ***Osteoporosis***:
    - Continue to meet qualifying criteria.
    - Responding to treatment with evidence of maintenance or improved T-Score on DEXA scan.

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: ***For the treatment of Hypoparathyroidism***
- ❒ **Duration of Approval:** Usual dosing is 20 mcg subcutaneously once daily.
  - **Initial Authorization**: ***Hypoparathyroidism***-3 months
  - **Continuation of Therapy**: ***Hypoparathyroidism***-1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Parathyroid Hormone level (PTH) checked to rule out hyperparathyroidism
  - Trial and failure/intolerance to a compliant (at least 2 months) regimen of formulary medications used to treat hypoparathyroidism (Calcijex/ Rocaltrol, ergocalciferol)
- ❒ **Age:** >18 years old, Safety and efficacy have not been established in pediatrics.
- ❒ **Route of Administration:** Subcutaneously

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - ***Hypoparathyroidism***:
  - Patient is tolerating and responding to treatment

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- See other special considerations.

Other special considerations:

- **Box Warning :**
    - **Potential risk of osteosarcoma:** In male and female rats, teriparatide caused an increase in the incidence of osteosarcoma (a malignant bone tumor) that was dependent on dose and treatment duration. The effect was observed at systemic exposures to teriparatide ranging from 3 to 60 times the exposure in humans given a 20 mcg dose. Because of the uncertain relevance of the rat osteosarcoma finding to humans, prescribe teriparatide only to patients for whom the potential benefits are considered to outweigh the potential risk. Teriparatide should not be prescribed for patients who are at increased baseline risk for osteosarcoma (e.g., those with Paget disease of bone or unexplained elevations of alkaline phosphatase, pediatric and young adult patients with open epiphyses, patients with prior external beam or implant radiation therapy involving the skeleton).

GILENYA® / FINGOLIMOD

Drug Class: Multiple Sclerosis Agent - Sphingosine 1-phosphate receptor modulator

FDA-approved uses: Gilenya is indicated for the treatment of patients with relapsing forms of multiple sclerosis (MS) to reduce the frequency of clinical exacerbations and to delay the accumulation of physical disability.

Available dosage forms: 0.5mg Capsules

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Indicated for the treatment of patients with relapsing forms of multiple sclerosis including:
  - Relapsing-remitting multiple sclerosis [RRMS]
  - Secondary-progressive multiple sclerosis [SPMS] with relapses
  - Progressive-relapsing multiple sclerosis [PRMS]
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:**
  - Board-certified Neurologist
  - Board-certified Multiple Sclerosis physician specialist
  - Consult with a Board-certified neurologist or physician specialist with experience in prescribing multiple sclerosis therapy (submit consultation notes)
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - A definitive diagnosis of a relapsing form of multiple sclerosis as defined by the McDonald criteria.
  - Expanded Disability Status Scale (EDSS) score between 0 and 5 (disability severe enough to impair full daily activities) **OR** documentation supporting the disability within this range
  - Documented inadequate response (to at least 6 months of therapy), intolerance, FDA labeled contraindication, or hypersensitivity to an interferon beta product (Avonex®, Rebif®, Betaseron®, or Extavia®) **AND** a non-interferon, glatiramer acetate (Copaxone®).
    - **NOTE:** "Needle phobia" or "needle fatigue" is not considered an intolerance or contraindication to the first-line disease-modifying therapies (DMT's)
    - Inadequate response is defined as meeting **TWO** of the following three criteria during treatment with one of these agents:
      - Increase in frequency (at least two clinical relapses within the past 12 months), severity and/or sequelae of relapses
      - Changes in MRI: continues to have CNS lesion progression as measured by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions and/or T1 hypointense lesions)
      - Increase in disability progression: Sustained worsening of EDSS score, routine neurological observation, mobility, **or** ability to perform activities of daily living

- ❒ **Documentation Requirements, continued** (e.g. Labs, Medical Record, Special Studies):
    - Confirmation of **ONE** of the following from the Prescriber **AND** by verifying in member's prescription profile.
        - Member is not currently being treated with another disease-modifying agent for MS
        - Member is currently being treated with another disease-modifying agent for MS **AND** the disease-modifying agent will be discontinued before starting the requested agent
    - All of the following labs or exams within the last 6 months
        - CBC
        - LFT's and bilirubin levels
        - Negative pregnancy if female
        - EKG evaluation
        - Ophthalmic examination
    - Patient has documented history of chicken pox **OR** has had the varicella zoster vaccination **OR** has evidence of immunity (positive antibodies)
- ❒ **Quantity:** 30 capsules per month
- ❒ **Age:** 18 years of age or older
- ❒ **Gender:** male or female
- ❒ **Route of Administration:** Oral
- ❒ **Place of Service:** Outpatient

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Confirmation of **ONE** of the following from the Prescriber **AND** by verifying in member's prescription profile.
        - Member is not currently being treated with another disease-modifying agent for MS
        - Member is currently being treated with another disease-modifying agent for MS **AND** the disease-modifying agent will be discontinued before starting the requested agent
    - **Adherence to Therapy**
        - Member compliance with therapy as verified by Prescriber and member's medication fill history (review prescription history for compliance)
            - ***NOTE:*** *Therapy may be discontinued due to compliance issues or poor adherence upon agreement among treating physician, member, and Medical Director*.
    - **Labs/Reports/Documentation required [ALL]**
        - CBC
        - LFT's and bilirubin levels
        - Negative pregnancy if female
        - EKG evaluation
        - Ophthalmic examination

Criteria for continuation of therapy, continued

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Stabilization or positive response to Gilenya® (fingolimod) treatment. Demonstrated efficacy as evidenced by (including but not limited to the following): **[ALL APPLICABLE]**
        - **Relapses**: A decrease in frequency, severity, sequelae relapses from baseline
        - **Radiologic evidence of disease activity:** Beneficial effect on MRI measures of disease severity (decrease in number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions and/or T1 hypointense lesions)
    - **Disability progression:** EDSS score remains less than or equal to 5.5 or stabilization/improvement routine neurological observation, mobility, or ability to perform activities of daily living
    - Validated patient reported outcome measure [i.e. Fatigue Impact Scale (FIS), Medical Outcome Study SF-36, etc]
        - *Fatigue Impact Scale (FIS) is a validated patient reported outcome measure that evaluates the effect of fatigue on the lives of people with MS. The Medical Outcome Study SF-36 is a self-administered health-reported quality of life outcome measure that is validated for several indications and patient populations*

Contraindications/Exclusions/Discontinuation:

- Steady progression of disability
- Drug toxicity or serious adverse reaction
- Non-FDA approved indications
- Authorization will not be granted if **ANY** of the following contraindications/exclusions to Gilenya® (fingolimod) therapy apply**:**
    - Myocardial infarction, unstable angina, stroke, TIA, decompensated heart failure requiring hospitalization or Class III/IV heart failure experienced within the past 6 months
    - History or presence of Mobitz Type II second-degree or third-degree atrioventricular (AV) block or sick sinus syndrome, unless patient has a functioning pacemaker
    - Baseline QTc interval ≥500 msec
    - Treatment with Class Ia or Class III anti-arrhythmic drugs
    - **NOTE:** "Needle phobia" or "needle fatigue" is not considered a contraindication.
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- For use as monotherapy therapy only:
    - Prescriber intends to use Gilenya as a single agent; no other disease-modifying multiple sclerosis medications are being administered concomitantly, including but not limited to: interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®), glatiramer acetate (Copaxone®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), teriflunomide (Aubagio®), or dimethyl fumerate (Tecfidera®)

GLATOPA® / GLATIRAMER ACETATE

Drug Class: Multiple Sclerosis modifying agents

FDA-approved uses: Multiple sclerosis**:** Treatment of patients with relapsing forms of multiple sclerosis

Available dosage forms: Prefilled Syringe, solution, subcutaneous: 20 mg/ml

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:** A relapsing form of multiple sclerosis
- ❒ **Duration of therapy:**
  - **Initial Authorization:** 6 months
  - **Continuation of therapy:** 6 months
- ❒ **Prescriber Specialty:** specialist: neurologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Submission of progress notes and lab results/test results/imaging establishing the diagnosis of a relapsing form of multiple sclerosis
- ❒ **Age:** >18 years of age
- ❒ **Route of Administration:** Subcutaneous Injection

Criteria for continuation of therapy:

- ❒ Requires certification from a neurologist that therapy has been effective, i.e. treatment has decreased relapses or diminished number of lesions on MRI

Contraindication/Exclusion/Discontinuation:

- **Systemic reactions:** Immediate post injection systemic reactions occur in a substantial percentage of patients (approximately 16% [20 mg/mL] and approximately 2% [40 mg/mL] in studies); symptoms (anxiety, chest pain, constriction of the throat, dyspnea, flushing, palpitations, and urticaria) are usually self-limited and transient. These symptoms generally occur several months after initiation of treatment
- Hypersensitivity to glatiramer acetate, mannitol, or any component of the formulation

Other special considerations:

- **Chest pain:** May or may not occur with the immediate postinjection reaction; described as a transient pain usually resolving in a few minutes; often unassociated with other symptoms. Episodes usually begin 1 month or more after initiation of treatment.
- **Lipoatrophy:** May occur locally at injection site at various times after treatment (sometimes after several months) and may not resolve; to possibly minimize occurrence, advise patient to follow proper injection technique and rotate site with each injection. Skin necrosis has also been observed.
- **Immune response:** Although there has not been a systematic evaluation of glatiramer's potential to affect other immune functions, it may interfere with recognition of foreign antigens undermining the body's tumor surveillance and defense system against infection.
- **Antigenic:** Glatiramer acetate is antigenic, and may possibly lead to the induction of untoward host responses. Glatiramer acetate–reactive antibodies (IgG subtype) form in most patients.
- **Drug-drug interactions:** Potentially significant interactions may exist, requiring dose or frequency adjustment, additional monitoring, and/or selection of alternative therapy.
- **Hypersensitivity reactions:** Anaphylactoid reactions (rare) have been reported
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

GROWTH HORMONES

GENOTROPIN® AND GENOTROPIN MINIQUICK® / SOMATROPIN

HUMATROPE® / SOMATROPIN

NORDITROPIN FLEXPRO® / SOMATROPIN

NORDITROPIN NORDIFLEX PEN® / SOMATROPIN

NUTROPIN AQ® AND NUTROPIN AQ NUSPIN® / SOMATROPIN

OMNITROPE® / SOMATROPIN

SAIZEN® AND SAIZEN CLICK EASY® / SOMATROPIN

ZOMACTON® / SOMATROPIN

ZORBTIVE® / SOMATROPIN

Drug Class: Growth Hormones

FDA-approved uses:

- ❒ The FDA has approved the use of rhGH for treatment of children with short stature associated with GHD, chronic renal insufficiency, Turner's syndrome, Prader-Willi syndrome, children who are small for gestational age and who do not manifest catch-up growth by age 2, and, most recently, for idiopathic short stature (ISS). Although one rhGH product is approved for treatment of acquired immunodeficiency syndrome (AIDS) wasting and cachexia in adults, it has not yet been approved for use in children. The FDA-approved indications for rhGH products are as follows:
    - **Pediatrics:**
        - Growth hormone deficiency causing slow growth
        - Growth hormone deficiency causing infantile hypoglycemia
        - Short stature or growth failure due to:
            - Turner syndrome
            - Prader-Willi syndrome
            - Chronic renal insufficiency prior to transplantation
            - Noonan's syndrome
            - SHOX (short stature homeobox-containing gene) deficiency
            - Idiopathic short stature
            - Small for gestational age
            - Central nervous system tumor treated with radiation (requires medical clearance from the treating oncologist)

FDA-approved uses, continued:

- **Adults**
  - Growth hormone deficiency due to hypothalamic or pituitary condition
  - Child onset growth hormone deficiency continuing into adulthood
  - Short-bowel syndrome
  - HIV Wasting (refer to Serostim prior authorization guidelines)

Human growth hormone products currently available in the United States are exclusively produced from recombinant technology in the form of somatropin. Although recombinant human growth hormone (rhGH) products are produced by different manufacturers, the molecular structure is the same for each brand name for somatropin, hence there are no expected differences in efficacy between products. Growth hormone products used in GHD (and other indications) are all approved as containing the identical sequence of 191 amino acids constituting the naturally occurring pituitary human growth hormone

Recommended Dosage:

DOSAGE RECOMMENDATIONS FOR GH[50]	
Clinical condition	**Dose** (μg/kg/day)**
GHD • Children • Adolescents • Adults*	 25-50 25-100 6-25
Chronic renal insufficiency	50
Turner syndrome	50
PWS	35-50
Reference: Lawson Wilkins Pediatric Endocrinology Society	

Dosage prescribed is within the FDA-approved labeling based on member's confirmed diagnosis. Dosage should be 0.1-0.3 mg/day subcutaneously, and titrate monthly to effect. Adult dosage greater than 0.3 mg/day will not be authorized.

Available dosage forms:

- ❒ *Norditropin FlexPro – 5 mg/1.5ml, 10 mg/1.5ml, 15 mg/1.5ml, 30 mg/3ml
- ❒ Genotropin – Cartridge 5 mg, 12 mg
- ❒ Genotropin MiniQuick – Solution 0.2 mg, 0.4 mg, 0.6 mg, 0.8 mg, 1 mg, 1.2 mg, 1.4 mg, 1.6 mg, 1.8 mg, 2 mg
- ❒ Humatrope – Vial 5 mg, Cartridge 6 mg, 12 mg, 24 mg
- ❒ Norditropin NordiFlex Pen – 30 mg/3ml
- ❒ Nutropin AQ – NuSpin 5 mg/2 ml, 10 mg/1ml, 20 mg/2ml, Pen 10 mg/2ml, 20 mg/2ml
- ❒ Omnitrope – Vial 5.8 mg, Cartridge 5 mg/1.5ml, 10 mg/1.5ml
- ❒ Saizen – Vial 5 mg, 8.8 mg, Click Easy Cartridge 8.8 mg
- ❒ Zomactin – Vial 5 mg, 10 mg
- ❒ Zorbtive – Vial 8.8 mg

Covered on the Managed Care Common Formulary

Coverage Criteria/Limitations for initial authorization:

- ❒ **Prescriber Specialty:** Prescribed by a specialist based on the condition treated (e.g., endocrinologist (for adults) or pediatric endocrinologist (for children), HIV specialist, nephrologist)
- ❒ **Neonates/Infants:**
  - Random GH level <20ng/ml (by RIA test).
  - Abnormal IGFBP-3 (in infants)
  - Other causes have been ruled out or treated (hypothyroidism, metabolic disorders)
- ❒ **Children:**
  - Not used for idiopathic short stature (not considered medically necessary)
  - Not used for growth promotion in pediatric patients with epiphyseal closure (linear growth can no longer occur. i.e., bone age>14 yrs old). The potential for achieving additional growth after Tanner 4-5 (full maturity) is small as this correlates with epiphyseal closure.
  - Other factors contributing to growth failure have been ruled out, or are being treated (e.g., inadequate caloric intake/malnutrition/eating disorder, untreated hypothyroidism – patients need normal TSH, T4)
  - Recent (within the last 3 months) height more than 2 SDS below the mean (<3rd percentile) for age and sex
  - Recent (within the last 3 months) weight
  - Pretreatment growth velocity below normal for age and sex

ADDITIONAL INFORMATION REQUIRED (BASED ON DIAGNOSIS):

Pediatric Treatments:

Diagnosis: *Child – Growth Hormone Deficiency (GHD):*

(Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen, Tev-Tropin)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Fasting Growth Hormone Stimulation testing with arginine (ARG), clonidine, glucagon, insulin tolerance test (ITT) and/or levodopa
  - Peak levels < 10 mcg/L from 2 different agents are required if the cause of growth failure is unknown
  - If cause of GHD is known, only 1 peak level < 10 mcg/L will be required:
    - Structural or developmental abnormalities: e.g. anencephaly, pituitary aplasia
    - Genetic disorders: e.g., *PROP1* and *PIT1* mutations, septo-optic dysplasia
    - Acquired causes: e.g., craniopharyngeomas*, cranial irradiation, brain surgery, head trauma, CNS infections
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - Documentation to support final height has not been achieved
    - No evidence of epiphyseal closure **AND**
    - Growth velocity is > 5cm/year on current dose or < 5 cm/year with intended dose increase (Note: Growth velocity will typically decrease as final height is approached (growth velocity <2 cm/year).
    - *For Chronic Renal Insufficiency:* there is insufficient data regarding the benefit of treatment beyond three years.

Pediatric Treatments, continued

Diagnosis: *Child – Turner Syndrome, Prader-Willi Syndrome, SHOX deficiency or Noonan Syndrome:*
(Prader-Willi Syndrome: Genotropin, Tev-Tropin, Omnitrope) (Turner Syndrome: Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope) (SHOX: Humatrope) (Noonan Syndrome: Norditropin)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documentation to support the diagnosis (e.g., Turner Syndrome confirmed by karyotype studies, Prader-Willi Syndrome confirmed by genetic testing)
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - Documentation to support final height has not been achieved
    - No evidence of epiphyseal closure **AND**
    - Growth velocity is > 5cm/year on current dose or < 5 cm/year with intended dose increase (Note: Growth velocity will typically decrease as final height is approached (growth velocity <2 cm/year).
    - *For Chronic Renal Insufficiency:* there is insufficient data regarding the benefit of treatment beyond three years.

Diagnosis: *Child – Chronic Renal Insufficiency (CRI):*
(Nutropin)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documented diagnosis of CRI
  - Patient has not received a renal transplant
  - Existing metabolic abnormalities (e.g., malnutrition, acidosis, secondary hyperparathyroidism and hyperphosphatemia - correct phosphorus to < 1.5 times the upper limit for age) have been corrected
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - Documentation to support final height has not been achieved
    - No evidence of epiphyseal closure **AND**
    - Growth velocity is > 5cm/year on current dose or < 5 cm/year with intended dose increase (Note:Growth velocity will typically decrease as final height is approached (growth velocity <2 cm/year).
    - *For Chronic Renal Insufficiency:* there is insufficient data regarding the benefit of treatment beyond three years.

Pediatric Treatments, continued

Diagnosis: ***Child – Small for Gestational Age (SGA) with failure to catch-up by 2 years of age:***
(Genotropin, Humatrope, Norditropin, Omnitrope)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - At least 2 years of age
  - Birth length or weight < 3rd percentile for gestational age, or
  - Birth weight < 2500 grams at a gestational age of more than 37 weeks
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - Documentation to support final height has not been achieved
    - No evidence of epiphyseal closure AND
    - Growth velocity is > 5cm/year on current dose or < 5 cm/year with intended dose increase (Note:Growth velocity will typically decrease as final height is approached (growth velocity <2 cm/year).
    - *For Chronic Renal Insufficiency:* there is insufficient data regarding the benefit of treatment beyond three years.

Adult Treatments

Diagnosis: ***Adult – Idiopathic GH deficiency (Childhood-onset):***
(Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documented diagnosis of idiopathic childhood-onset GHD
  - Growth hormone must not be taken for 1-3 months before repeat GH stimulation test and IGF-1 were drawn
  - Growth hormone stimulation testing:
    - **Insulin Tolerance Test (ITT):**
      - Considered Gold standard test
      - Peak ≤ 5 mcg/L indicative of GHD
    - **Glucagon (for patients who are unable to take ITT):**
      - Alternative test if recombinant GHRH is unavailable or if ITT is contraindicated (seizures, CVD, or cerebrovascular disease)
      - Peak ≤ 3 mcg/L indicative of GHD
    - **Note:** Levodopa and clonidine tests are not recommended
  - Baseline serum IGF-1
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - if IGF-1 is low but dose is being increased or 1 year if IGF-1 is at a stable range

Adult Treatments, continued

Diagnosis: *Adult – GH deficiency due to a known cause (Childhood-onset):*
(Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documented diagnosis of childhood-onset GHD due to a known cause (structural lesions, genetic disorders, acquired causes)
  - Baseline serum IGF-1
  - **Note:** for conditions other than GHD, such as Turner Syndrome and small for gestational age, there is no proven benefit to continuing GH treatment into adulthood once final height is achieved.
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - if IGF-1 is low but dose is being increased or 1 year if IGF-1 is at a stable range

Diagnosis: *Adult – Onset GH deficiency:*
(Genotropin, Humatrope, Norditropin, Nutropin, Omnitrope, Saizen)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documented diagnosis of GHD acquired as an adult due to a known cause (e.g., surgery, cranial irradiation, panhypopituitarism)
  - Baseline IGF-1
  - Growth hormone stimulation test:
    - **Insulin Tolerance Test (ITT):**
      - Considered Gold standard test
      - Peak ≤ 5 mcg/L indicative of GHD
    - **Glucagon (for patients who are unable to take ITT):**
      - Alternative test if recombinant GHRH is unavailable or if ITT is contraindicated (seizures, CVD, or cerebrovascular disease)
      - Peak ≤ 3 mcg/L indicative of GHD
    - **Note:** Levodopa and clonidine tests are not recommended
  - If GH deficiency is due to traumatic brain injury and aneurysmal subarachnoid hemorrhage, GHD may be transient; therefore, GH stimulation testing should be performed at least 12 months after the event
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Approval:** 6 months
    - if IGF-1 is low but dose is being increased or 1 year if IGF-1 is at a stable range

Adult Treatments, continued

Diagnosis: ***Adult – HIV Wasting/cachexia:***
(Serostim)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documented height, weight, and ideal body weight
  - Patient had progressive weight loss below IBW over the last year which cannot be explained by a concurrent illness other than HIV infection
  - Documented adequate caloric intake
  - Failure of megestrol and dronabinol
  - On antiretroviral therapy
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 3 months
  - **Continuation of Approval:** 12 weeks (maximum 48 weeks)
    - Requires: documentation to support response to therapy

Diagnosis: ***Adult – Short Bowel Syndrome:***
(Zorbtive)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Age > 18 years of age
  - Patient is receiving specialized nutrition (e.g. TPN or PPN)
- ❒ **Duration of Approval:**
  - **Initial Authorization:** One 4-week course
  - **Continuation of Approval:** Approve 4 weeks, No renewals

Diagnosis: ***Adult – Treatment of excess abdominal fat in HIV-infected patients with lipodystrophy:***
(Egrifta)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - 18-65 years of age
  - **Men:** waist circumference ≥ 95 cm (37.4") and waist-to-hip ratio ≥ 0.94
  - **Women:** ≥ 94 cm (37.0") and waist-to-hip ratio ≥ 0.88
  - On antiretroviral therapy
  - Patient is at risk for medical complications due to excess abdominal fat
  - Contraindications: No disruption of the hypothalamic-pituitary axis (e.g. hypothalamic-pituitary-adrenal (HPA) suppression) due to hypophysectomy, hypopituitarism, pituitary tumor/surgery, radiation therapy of the head or head trauma, active malignancy, known hypersensitivity to tesamorelin and/or mannitol, and pregnancy
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 3 months
  - **Continuation of Approval**: Initial Renewal: 6 months
    - Requires: documentation to support response to therapy, decrease in baseline waist circumference, and documentation that IGF-1, and A1C is being monitored

Contraindications/Exclusions/Discontinuation:

- Active malignancy
- Critical illness (e.g., after complications following open heart or abdominal surgery, multiple trauma, acute respiratory failure or similar conditions)
- Known hypersensitivity to growth hormone or to any of its excipients
- Intracranial hypertension
- Diabetic retinopathy, proliferative or pre-proliferative *(Note: Diabetes mellitus is not a contraindication, however GH therapy might impede the control of type 2 diabetes)*
- Pregnancy or lactation: Pregnancy is not an absolute contraindication, but GH therapy during pregnancy is recommended if clearly needed. Category B (Genotropin, Omnitrope, Saizen, Serostim, and Zorbtive). Category C (Accretropin, Humatrope, Norditropin, Nutropin, Nutropin AQ, and Tev-Tropin).
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

HUMIRA® / ADALIMUMAB

Drug Class: Anti-Inflammatory Tumor Necrosis Factor Inhibiting Agents, TNF=alpha set

FDA-approved uses:

- ❒ **Ankylosing spondylitis (AS):** For reducing signs and symptoms in adults with active ankylosing spondylitis.
- ❒ **Crohn disease:** For reducing signs and symptoms, as well as inducing and maintaining clinical remission, in adult and pediatric patients 6 years and older with moderately to severely active Crohn disease who have had an inadequate response to conventional therapy; for reducing signs and symptoms, as well as inducing clinical remission, in these patients if they have also lost response to or are intolerant to infliximab (adults) or corticosteroids or immunomodulators such as azathioprine, 6-mercaptopurine, or methotrexate (6 years and older).
- ❒ **Hidradenitis suppurativa:** Treatment of moderate to severe hidradenitis suppurativa.
- ❒ **Juvenile idiopathic arthritis (JIA)*:*** For reducing signs and symptoms of moderately to severely active polyarticular juvenile idiopathic arthritis in pediatric patients 2 years and older, alone or in combination with methotrexate.
- ❒ **Plaque psoriasis (PsO):** For the treatment of adults with moderate to severe chronic plaque psoriasis who are candidates for systemic therapy or phototherapy, and when other systemic therapies are medically less appropriate.
- ❒ **Psoriatic arthritis (PsA):** For reducing signs and symptoms, inhibiting the progression of structural damage, and improving physical function in adults with active psoriatic arthritis, alone or in combination with non-biologic disease-modifying antirheumatic drugs (DMARDs).
- ❒ **Rheumatoid arthritis (RA):** For reducing signs and symptoms, inducing major clinical response, inhibiting the progression of structural damage, and improving physical function in adults with moderately to severely active rheumatoid arthritis (RA), alone or in combination with methotrexate or other non-biologic DMARDs.
- ❒ **Ulcerative colitis (UC):** For inducing and sustaining clinical remission in adults with moderately to severely active ulcerative colitis who have had an inadequate response to immunosuppressants such as corticosteroids, azathioprine, or 6-mercaptopurine.
- ❒ **Off-label uses*:***
    - o Pyoderma gangrenosum
    - o Uveitis (adults)
    - o Uveitis (children/adolescents)

Available dosage forms:

- ❒ Humira Prefilled Syringe Kit 10 mg/0.2ml, 20 mg/0.4ml, 40 mg/0.8ml
- ❒ Humira Pediatric Crohn's prefilled syringe kit 40 mg/0.8ml
- ❒ Humira Pen Injector Kit 40 mg/0.8ml
- ❒ Humira Pen-Crohn's starter pen injector kit 40 mg/0.8ml
- ❒ Humira Pen-Psoriasis starter pen injector kit 40 mg/0.8ml

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:** FDA approved use as listed above
- ❒ **Prescriber Specialty:** Prescribed by, or in consultation with a specialist (based on indication- rheumatologist, dermatologist, gastroenterologist)

ADDITIONAL INFORMATION REQUIRED (BASED ON DIAGNOSIS)

Diagnosis: ***Ankylosing Spondylitis (AS):***

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Presence of active disease for at least 4 weeks
  - BASDAI score of 4 or more
  - Trial and failure of 2 different NSAIDS, steroid products, sulfasalazine or methotrexate within the 3 months
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** Based on FDA dosing. Partial Fill Restrictions may apply
  - 40mg subcutaneously every other week
- ❒ **Age:** At least 18 years of age
- ❒ **Route of Administration:** Injection

Diagnosis: ***Hidradenitis suppurativa:***

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Clinically diagnosed with moderate to severe hidradenitis suppurativa
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Documentation of use of general measures:
    - Education and support
    - Avoidance of skin trauma
    - Hygiene
    - Dressings
    - Smoking cessation
    - Weight management
    - Diet
  - Documentation of adequate trial and failure if Infliximab (Remicade)
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** Based on FDA dosing. Partial Fill Restrictions may apply
- ❒ **Route of Administration:** Injection

Diagnosis: ***Plaque Psoriasis****:*

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Trial and failure of methotrexate for 3 consecutive months or contraindication to methotrexate
  - Patients has ∃10% BSA involvement or affected area includes palms, soles, head, next, or genitalia **AND**
  - Intolerant to topical agents, topical immunomodulators, systemic therapy (methotrexate, cyclosporine, or acitretin)
  - Trial and failure of UVB or UVA therapy or contraindication to therapy
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** 80mg day one, then 40mg every other week
- ❒ **Route of Administration:** Injection

Diagnosis: ***Rheumatoid Arthritis/Psoriatic Arthritis (Adults):***

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Trial and failure of at least 3 consecutive months of methotrexate or contraindication/intolerance to methotrexate **AND**
  - Patient has tried and failed at least 1 other non-biologic DMARD (sulfasalazine, cyclosporine, hydroxychloroquine or leflunomide) as sequential monotherapy for 3 months each or in combination for at least 3 months or contraindication/intolerance
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:**
  - 40mg subcutaneously every other week
  - For RA, may be increased to 40mg every week
- ❒ **Route of Administration:** Injection

Diagnosis: ***Juvenile idiopathic arthritis (JIA):***

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Trial and failure of at least 3 consecutive months of methotrexate or contraindication/intolerance to methotrexate **AND**
  - Patient has tried and failed at least one other non-biologic DMARD for 3 months
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** (2 years and older)
  - **10 kg to < 15 kg:** 10mg every other week
  - **15 to 30 kg:** 20mg every other week
  - **Greater than 30 kg:** 40mg every other week
- ❒ **Age:** 2 years and older
- ❒ **Route of Administration:** Injection

Diagnosis: ***Crohn's Disease (CD)/Ulcerative Colitis (UC):***

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Trial and failure of parenteral methotrexate for 3 months or contraindication/intolerance to methotrexate
  - Trial and failure of oral or intravenous corticosteroids for at least one month or a contraindication/intolerance to corticosteroids
  - Trial and failure of 2 or more of the following for 3 consecutive months or a contraindication or intolerance to
    - Azathioprine
    - Budesonide
    - Oral or rectal aminosalicylates (e.g., mesalamine, sulfasalazine, balsazide disodium)
    - Cyclosporine
    - Mercaptopurine (CD, UC)
    - Remicade
- ❒ **Duration of Approval:**
  - **Initial Authorization:**
    - UC patient's initial coverage is for 2 months. *Must have evidence of clinical remission by week 8 for continuation.
    - 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** Adult Crohn's Disease (CD) and Ulcerative Colitis (UC)
  - **Day 1:** 160 mg or 80 mg for two consecutive days
  - **Day 15:** 80 mg
  - **Day 29/Maintenance:** 40 mg every other week
  - UC initial coverage for 2 months, followed by 12 months continuation
- ❒ **Route of Administration:** Injection

Diagnosis: ***Severe Ulcerative Colitis/Crohn's Disease:*** For moderate to severe disease dosed more frequently than every other week requires:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Patient must have previously responded to Humira doses every other week
  - Patient must be experiencing a flare
  - The flare must be likely to result in hospitalization
  - Approved for 2 months, for treatment of the flare and then must be resumed at every other week dosing
- ❒ **Duration of Approval:**
  - **Initial Authorization:**
    - UC patient's initial coverage is for 2 months. *Must have evidence of clinical remission by week 8 for continuation. Reauthorization for additional 12 months.
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** Adult Crohn's Disease (CD) and Ulcerative Colitis (UC)
  - **Day 1:** 160 mg or 80 mg for two consecutive days
  - **Day 15**: 80 mg
  - **Day 29/Maintenance:** 40 mg every other week
  - UC initial coverage for 2 months, followed by 12 months continuation
- ❒ **Route of Administration:** Injection

Diagnosis: ***Pediatric Crohn's Disease:***

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies)
  - Documentation of a negative TB test within last 12 months
  - Must not have heart failure
  - Patient has had an inadequate response to all of the following:
    - Corticosteroids
    - Azathioprine
    - Mercaptopurine
    - Methotrexate
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Approval**: 1 year
- ❒ **Quantity:** (6 years and older)
  - **17 to less than 40 kg**
    - **Day 1:** 80mg
    - **Day 15:** 40mg
    - **Day 29/Maintenance:** 40mg every other week
  - **40 kg and above:**
    - **Day 1:** 160mg or 80mg for two consecutive days
    - **Day 15**: 40mg
    - **Day 29/Maintenance:** 40mg every other week
- ❒ **Age:** 6 years of age or older
- ❒ **Route of Administration:** Injection

Criteria for continuation of therapy:

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Documentation by respective specialty that the patient continues to have a beneficial response to therapy.

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- Patient receiving additional DMARD therapy.

Other special considerations:

- Additional information may be required on a case-by-case basis to allow for adequate review. Aminosalicylates, corticosteroids, methotrexate, nonsteroidal anti-inflammatory drugs, analgesics, immunomodulatory agents (e.g., 6-mercaptopurine, azathioprine), and/or other non-biologic DMARDs may be continued during treatment with adalimumab.
- **Black Box Warning:** Increased risk of serious infections and malignancy.

HUMULIN R U-500 / INSULIN REGULAR

Drug Class: Human Insulins - Short Acting

FDA-approved uses: To improve glycemic control in adult and pediatric patients with diabetes mellitus requiring more than 200 units of insulin per day.

Available dosage forms: 500 units/mL, 20mL vial (containing 10,000 units of insulin)

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:**
  - FDA-approved indication
  - If request is for a non-FDA approved indication, the request must be for a "medically accepted indication" as noted in the following compendia:
    - American Hospital Formulary Drug Service (AHFS-DI)
    - Micromedex DrugDex
    - Clinical Pharmacology
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documentation demonstrating requirement of more than 200 units of insulin per day.
- ❒ **Route of Administration:** Subcutaneous injection

Criteria for continuation of therapy

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - The above criteria has been met

Contraindications/Exclusions/Discontinuation:

- When above criteria are not met
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

IMITREX® INJECTION / SUMATRIPTAN

Drug Class: Migraine Therapy – Selective Serotonin Agonists 5-HT(1)

FDA-approved uses: Cluster Headaches and Migraines

Available dosage forms: Sumatriptan Succinate Pen 4 mg/0.5mL, Single Dose Prefilled Syringe Cartridge 4 mg/0.5ml, 6 mg/0.5ml, Refill 6 mg/0.5ml, Vial 6 mg/0.5mL

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Migraine
- ❒ **Duration of Approval:**
  - **Initial Authorization:** up to 3 months (12 weeks)
  - **Continuation of Therapy:** Re-authorization for continuation of treatment is required **every 6 months** to determine continued need based on documented positive clinical response
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documentation of migraine induced vomiting
  - Failed/intolerant to at least **one** formulary preferred alternative products (triptans) tablet
    - Sumatriptan tablet
    - Naratriptan tablet
    - Rizatriptan tablet

    AND
  - Failed/intolerant to at least **one** formulary preferred alternative products (triptans) orally disintegrating tablet
    - Rizatriptan ODT tablet
- ❒ **Prescriber Specialty:** Neurologist or pain management specialist
- ❒ **Quantity:**
  - Maximum 4mL per month
  - 6mg SC per headache, may repeat 1 hour after first dose, maximum 12mg/day
- ❒ **Age:** Adults. Safety and efficacy has not been determined for adolescents and children
- ❒ **Route of Administration:** Subcutaneous injection
- ❒ **Place of Service**: Sumatriptan injections are considered a self-administered treatment

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Maintenance therapy may be authorized when therapy has demonstrated efficacy as evidenced by an improvement in symptom management after initial therapy.
  - Documentation of improvement is required for continuation of therapy.

Contraindications/Exclusions/Discontinuation:

- History, symptoms, or signs of ischemic cardiac disease, peripheral vascular disease, uncontrolled hypertension.
- Within 24 hours of ergot-type drugs or within 2 weeks of discontinuing MAOIs
- Basilar headaches or hemiplegic migraine
- Hypersensitivity to sumatriptan or any of its components.
- **Patients with Hepatic Impairment Dosing**
    - Hepatic impairment may cause unpredictable increases in the bioavailability of orally administered sumatriptan. Do not exceed 50 mg/dose PO. Hepatic impairment does not significantly affect intranasal or subcutaneous sumatriptan. All formulations are contraindicated for use in patients with severe hepatic impairment.
- **Therapy may be discontinued** if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
    - Poor response to treatment as evidenced by physical findings and/or clinical symptoms following the initial 12 weeks approval for coverage
    - Intolerable adverse effects or drug toxicity

INCRELEX® / MECASERMIN

Drug Class: Insulin like growth factor 1 hormones

FDA-approved uses:

- ❒ Severe primary IGF-1 deficiency:
  - mutation in the GH-receptor
  - mutation in the post-GHR signaling pathway
  - IGF-1 gene defects
- ❒ Growth hormone gene deletion and have developed neutralizing antibodies to growth hormone

Available dosage forms: 10mg/ml multi-dose vial (40mg/ vial)
Recommended Dosage: Dosage of mecasermin should be individualized for each patient.

- ❒ The recommended starting dose of Increlex® is 0.04–0.08 mg/kg twice daily by subcutaneous injection.
- ❒ If well-tolerated for at least one week, the dose may be increased by 0.04 mg/kg per dose, to the maximum dose of 0.12 mg/kg given twice daily.

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Member has **ONE** of the following diagnoses:
  - Severe primary IGF-1 deficiency:
    - mutation in the GH-receptor
    - mutation in the post-GHR signaling pathway
    - IGF-1 gene defects
  - Growth hormone gene deletion and have developed neutralizing antibodies to growth hormone
- ❒ **Prescriber Specialty:** endocrinologist or pediatric endocrinologist.
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, and Special Studies):
  *Documentation of **ALL** of the following is required*:
  - Current height measurement at less than the 3rd percentile for age and sex
  - IGF-1 level greater than or equal to 3 standard deviations below normal (based on lab reference range for age and sex)
  - For Primary IGFD:
    - Normal or elevated growth hormone levels (Stimulation testing is not required when levels are normal or high).
      **Exception: Diagnosis of growth hormone gene deletion.*
  - Epiphyses must be confirmed as open for members age 10 and older (submit radiograph report).
  - Parental height (height of each parent, if available, or explanation of why not available – such as child adopted, or one parent no longer involved and is unavailable for measurement)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, and Special Studies):
  *Documentation of **ALL** of the following is required*:-**Continued –**
    - Clinically determined growth failure as defined by abnormally low growth rate velocity
      - Abnormal growth velocity is defined by the following:
        - A history of lower than normal growth velocity, as shown by growth charts spanning at least 6 months of time, **and**
        - Height: Baseline height must be < the 3rd percentile or > 2 standard deviations [SD] below the mean for gender and age, a measure of the degree of short stature.
      - Prescriber to submit member's height and weight measurements:
        - These measurements must be logged in a table and plotted on standard CDC growth chart.
        - Height and weight measures must cover at least a one-year time-span* **Exception: If a member is in puberty, bone age may be advancing secondary to sex hormone production. If previous growth data cannot be found to provide the "one-year" or longer time-span of data, then sexual maturity rating (Tanner Staging) and measurement of sex hormones may be submitted with only 6 months of growth data.*
- ❒ **Age**: Member is > 2 years and < 18 years of age

Contraindications/Exclusions/Discontinuation:

- Closed epiphyses
- Active or suspected neoplasia
- Allergy to mecasermin (IGF-1) or any of the inactive ingredients in mecasermin
- Intravenous (IV) administration
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations: Member is not receiving concurrent growth hormone therapy **or** pharmacologic doses of corticosteroids.

LARIAM® / MEFLOQUINE

Drug Class: Antimalarial

FDA-approved uses:

- ❒ **Treatment of Acute Malaria Infections**: Mefloquine is indicated for the treatment of mild to moderate acute malaria caused by mefloquine-susceptible strains of *P. falciparum* (both chloroquine-susceptible and resistant strains) or by *P. vivax.*
- ❒ **Prevention of Malaria:** Mefloquine is indicated for the prophylaxis of *P. falciparum* and *P. vivax* malaria infections, including prophylaxis of chloroquine-resistant strains of *P. falciparum.*

Available dosage forms: 250mg Tablets

Coverage Criteria/Limitations for initial authorization [*30 days for acute treatment; 3 months for prophylaxis*]:

- ❒ **Diagnoses:** treatment or prevention of malaria
- ❒ **Duration of Approval:**
    - **Initial Authorization:**
        - Acute Treatment: 30 days
        - Prophylaxis: 3 months
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Country/region where the patient will be traveling
    - For Acute Treatment:
        - cultures and sensitivities to support malaria diagnosis
    - For Malaria Prophylaxis:
        - date and duration of travel
        - Use of doxycycline
- ❒ **Quantity:** 5 tablets per 30 days
- ❒ **Gender:** male or female
- ❒ **Route of Administration:** oral
- ❒ **Place of Service:** outpatient

Contraindications/Exclusions/Discontinuation:

- Mefloquine should not be prescribed for prophylaxis in patients with active depression, a recent history of depression, generalized anxiety disorder, psychosis, schizophrenia or other major psychiatric disorders, or with a history of convulsions.
- Mefloquine is contraindicated with the use of ketoconazole.
- Mefloquine should be used with caution with potent CYP3A4 inhibitors and medications that prolong the QTc interval.
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

LIDODERM® / LIDOCAINE 5% PATCH

Drug Class: Dermatological - Topical Local Anesthetic Amides

FDA-approved uses: Post-herpetic neuralgia (PHN)

Available dosage forms: Lidocaine 5% patch

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Post-herpetic neuralgia (PHN) or diabetic neuropathic pain
- ❒ **Duration of Approval:**
  - **Initial Authorization:**
    - PHN: Up to 90 days
    - Neuropathic pain: initially 2 months
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - **For diabetic neuropathic pain only:** at least 2 of the following: gabapentin, tricyclic antidepressant, nerve block, trigger point injection, SNRIs, TENS unit, other:_____
- ❒ **Quantity:** Max 3 patches per day (may be cut to cover areas of most severe pain)

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

LOVAZA® / OMEGA-3-ACID ETHYL ESTERS

Drug Class: Antihyperlipidemic Agents - Dietary Source

FDA-approved uses: Hypertriglyceridemia, adjunct to diet in adults with triglyceride levels 500mg/dL or higher.

Available dosage forms: Oral capsule, Liquid filled 1GM

Coverage Criteria/Limitations for initial authorization:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Inadequate response, intolerance, or contraindication to treatment with two formulary fibric acid derivatives (fenofibrate, fenofibric acid, gemfibrozil)
  - Triglyceride level greater than or equal to 500 mg/dL
- ❒ **Quantity**: 4 capsules per day

Criteria for continuation of therapy

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Triglyceride level greater than or equal to 500 mg/dL

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

LOVENOX® / ENOXAPARIN

Drug Class: low **molecular weight heparin**

FDA-approved uses:

- ❒ Prophylaxis of DVT (abdominal surgery, knee & hip replacement)
- ❒ DVT with or without PE in patient.
- ❒ DVT without PE, outpatient
- ❒ Unstable angina and NSTEMI, inpatient
- ❒ Acute STEMI, inpatient

Available dosage forms:

- ❒ Generic Enoxaparin: *30 mg/0.3ml, *40 mg/0.4ml, *60 mg/0.6ml, *80 mg/0.8ml, *100 mg/ml, *120 mg/0.8ml, *150 mg/ml and 300mg/3ml
- ❒ Lovenox: 30 mg/0.3ml, 40 mg/0.4ml, 60 mg/0.6ml, 80 mg/0.8ml, 100 mg/ml, 120 mg/0.8ml, 150 mg/ml and 300mg/3ml

Covered on the Managed Care Common Formulary

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: FDA approved indication detailed above
- ❒ **Duration of therapy**: Dependent on condition treated.
  - **Initial Authorization:**
    - **DVT/PE prophylaxis (hip fracture or replacement surgery):** Up to 28-35days (4-5 weeks)
    - **DVT/PE prophylaxis (all other indications), DVT/PE treatment, bridge therapy:** 10 days or as requested
    - **Thrombosis prophylaxis during pregnancy:** Until 6 weeks after delivery (EDC required for authorization)
    - **Thrombosis prophylaxis in cancer patients:** 3-6 months or as requested
  - **Continuation of Approval:** To be determined in collaboration with the prescriber.
    - **For DVT/PE prophylaxis** it would be anticipated at minimum to be an additional 10 days per additional request.
    - **With thrombosis prophylaxis** a 3 month extension would be expected.
    - Neither **surgery related prophylaxis or pregnancy thrombosis prophylaxis** would be expected to be extended.
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  Extended courses (> 10 days of therapy) of enoxaparin are authorized for the following:
  - DVT prophylaxis in patients undergoing hip or knee replacement surgery
  - DVT prophylaxis in patients undergoing abdominal surgery
  - DVT/PE treatment in patients who are taking warfarin
  - Bridge therapy for perioperative warfarin discontinuation
  - Cancer patients with a high risk of thrombosis
  - Patients with restricted mobility during acute illness
  - Use of subcutaneous (SQ) unfractionated heparin (UFH) is required in prophylaxis in pregnancy

- ❒ **Documentation Requirements, continued** (e.g. Labs, Medical Record, Special Studies):
  Approval for all other acceptable indications not listed above:
  - Upon receipt of documentation to support the following:
    - The requested drug is medically necessary over formulary anticoagulants or warfarin due to a medical condition, contraindication/intolerance, or previous failure **AND**
    - There are no contraindications to therapy with the requested agent
- ❒ **Age restrictions:** >18 years of age.

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Criteria for the initial authorization must still be present. Bridge therapy and thrombosis prophylaxis would be considered for continued coverage but must be clearly outlined with length of treatment identified with explanation.
  - Length of renewal authorization is based on anticipated length of therapy, indication and /or recent INR if on warfarin.

Contraindication/Exclusion/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- **Box Warning: Spinal/Epidural hematomas:**
  - Epidural or spinal hematomas may occur in patients who are anticoagulated with LMWHs or heparinoids and are receiving neuraxial anesthesia or undergoing spinal puncture. These hematomas may result in long-term or permanent paralysis. Consider these risks when scheduling patients for spinal procedures.

    Factors that can increase the risk of developing epidural or spinal hematomas in these patients include use of indwelling epidural catheters; concomitant use of other drugs that affect hemostasis, such as nonsteroidal anti-inflammatory drugs (NSAIDs), platelet inhibitors, and other anticoagulants; a history of traumatic or repeated epidural or spinal punctures; and a history of spinal deformity or spinal surgery. Optimal timing between the administration of enoxaparin and neuraxial procedures is not known.

    Monitor patients frequently for signs and symptoms of neurological impairment. If neurological compromise is noted, urgent treatment is necessary.

    Consider the benefits and risks before neuraxial intervention in patients anticoagulated or to be anticoagulated for thromboprophylaxis

Other special considerations: Enoxaparin is used in bridging to warfarin in a numbers of situations which requires INR monitoring.

MARINOL® / DRONABINOL

Drug Class: Antiemetic - Cannabinoids

FDA-approved uses:

- ❒ Appetite stimulation in AIDS patients
- ❒ Chemotherapy-induced nausea and vomiting

Available dosage forms: Capsules: 2.5 mg, 5 mg, 10 mg,

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnosis:** ***chemotherapy induced nausea and vomiting***
- ❒ **Duration of Approval**:
  - **Initial Authorization:** duration of the chemotherapy treatment
  - **Continuation of Therapy:** limited time -- determined based on the plan of care developed utilizing the chemotherapeutic agents
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient must be receiving chemotherapy and meet the following criteria:
    - Intolerant or refractory to first line agents such as Zofran
    - Patient must be under close supervision during the initial use and during dose adjustments due to its potential for altered mental status
    - The number of pills approved will be limited to the amount necessary for a single cycle of chemotherapy.
  - **For antiemetic purposed**: trial and failure, intolerance, or contraindication to an emetic regimen that includes a serotonin antagonist (ondansetron, granisetron), dexamethasone, promethazine, or prochlorperazine
  - **For cancer:** trial and failure, intolerance, or contraindication to an emetic regimen consistent with NCCN guidelines
- ❒ **Age restrictions:** adults and pediatrics
- ❒ **Prescriber Specialty**: Oncologist

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Decreased episodes of nausea and vomiting.

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnosis:** ***appetite stimulation in AIDS patients***
- ❒ **Duration of Approval**:
  - **Initial Authorization:** 3 months
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient must have AIDS with anorexia associated with weight loss
- ❒ **Age restrictions:** adults only
- ❒ **Prescriber Specialty**: Infectious Disease specialist

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Response to treatment with the patient stabilizing one's weight.

Contraindication/Exclusion/Discontinuation:

- Hypersensitivity to dronabinol, cannabinoids, sesame oil, or any component of the formulation
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Use cautiously in individuals with the following conditions as they may worsen with use of this product:
  - Seizure
  - Psychiatric disorders
  - Drug Abuse and dependence
  - Cardiovascular disorders.

MEPRON® / ATOVAQUONE

Drug Class: Antiprotozoal Agents - Other

FDA-approved uses: *Pneumocystis jiroveci* pneumonia:

- ❒ **Prophylaxis:** Prevention of *P. jiroveci* pneumonia (PCP) in adults and adolescents 13 years and older who are intolerant to trimethoprim-sulfamethoxazole (TMP-SMZ).
- ❒ **Treatment:**
  Acute oral treatment of mild to moderate PCP in adults and adolescents 13 years and older who are intolerant to trimethoprim-sulfamethoxazole.

Available dosage forms: 750mg/5ml Oral Suspension

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA approved uses as listed above
- ❒ **Prescriber Specialty:** Infectious Disease
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Failure or contraindication to TMP-SMZ
- ❒ **Quantity:** 21 day supply
- ❒ **Age:** 13 years or older
- ❒ **Route of Administration:** Oral

Contraindications/Exclusions/Discontinuation:

- Patient is noncompliant with medical or pharmacologic therapy.
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- Hypersensitivity to atovaquone or any component of the formulation.

NAMENDA® / MEMANTINE

Drug Class: Alzheimer's disease Therapy – NMDA Receptor Antagonists

FDA-approved uses: Alzheimer's Disease

Available dosage forms: Memantine Tablets 5 mg, 10 mg, 5 mg & 10 mg and Titration Pak

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Alzheimer's Disease
- ❒ **Duration of Approval**
  - **Initial Authorization:** may be authorized up to 3 months (12 weeks)
    - memantine titration pak: 1 month
    - memantine tablet: 2 months
  - **Continuation of Therapy:** Re-authorization for continuation of treatment is required every 12 months after initial authorization
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Diagnosis of Alzheimer's Disease supported by a validated cognitive assessment in the previous 6 months
  - Technician review of relevant patient fill history
  - Documentation of trial and failure of donepezil monotherapy
  - Use in combination with generic cholinesterase inhibitor
- ❒ **Quantity:**
  - **Titration pak** – 49 (1 pak) per year
  - **Tablets** – 60 per month after initiation
- ❒ **Age:** Adults and the Geriatric. Use is not indicated in adolescents or children
- ❒ **Route of Administration:** Oral

Criteria for continuation of therapy:

- **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Member currently meets ALL initial coverage criteria
  - Maintenance therapy may be authorized when therapy has demonstrated efficacy as evidenced by an improvement in symptom management after initial therapy. ***Documentation of improvement is required for continuation of therapy.***

Contraindications/Exclusions/Discontinuation:

- **Discontinuation of Treatment [ANY]**
  - Poor response to treatment as evidenced by physical findings and/or clinical symptoms following the initial 12 weeks approval for coverage
  - Intolerable adverse effects or drug toxicity
- **Patients with Renal Impairment Dosing**
  - **CrCl >= 30 ml/min**: No dosage adjustment is recommended for patients with mild to moderate renal impairment
  - **CrCl 5—29 ml/min:** After calculating estimated CrCl based on Cockroft-Gault equation, a target dose of 5 mg PO twice daily of immediate-release formulations is recommended (see adult dosage titration recommendations). A target dose of 14 mg/day of the extended-release capsule is recommended.
  - **CrCl < 5 ml/min:** No quantitative recommendation available; no specific information with respect to hemodialysis is available.
- Intolerable adverse effects or drug toxicity
- Persistent and uncorrectable problems with adherence to treatment
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

NEUPOGEN® / FILGRASTIM

Drug Class: Granulocyte Colony-Stimulating Factor (G-CSF)

FDA-approved uses:

- ❒ To decrease the duration of neutropenia in patients undergoing myeloablative chemotherapy followed by marrow transplantation for non-myeloid malignancies
- ❒ To decrease the incidence of infections from febrile neutropenia in patients with non-myeloid malignancies who are receiving myelosuppressive chemotherapy
- ❒ To reduce the time to neutrophil recovery and the duration of fever, following induction or consolidation chemotherapy treatment of patients with acute myeloid leukemia
- ❒ To reduce the incidence and duration of neutropenia sequelae, including fever, infections, or oropharyngeal ulcers, in symptomatic patients with congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia
- ❒ Mobilization of hematopoietic progenitor cells before autologous stem cell transplant
- ❒ Mobilization of hematopoietic progenitor cells in the donor before allogenic stem cell transplant
- ❒ Treatment of acute radiation exposure, to increase survival, in patients who receive myelosuppressive doses of radiation at a dose of 2 gray (Gy)

Available dosage forms:

- ❒ Injection: 300 mcg/mL in a single-use vial
- ❒ Injection: 480 mcg/1.6 mL in a single-use vial
- ❒ Injection: 300 mcg/0.5 mL in a single-use prefilled syringe
- ❒ Injection: 480 mcg/0.8 mL in a single-use prefilled syringe

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:**
  - FDA approved indications detailed above
  - ***Chemotherapy-induced neutropenia***
    - Chemotherapy regimen has approximately ≥ 20% risk of febrile neutropenia **OR**
    - Member is at high-risk for neutropenic complications (e.g., age > 65, pre-existing neutropenia or tumor involvement in the bone marrow, infection, renal or liver impairment, other serious co-morbidities)
    - Administered 24 – 72 hours after completion of chemotherapy
    - Patient is not receiving concurrent chemotherapy and radiation therapy

- ***Treatment of neutropenia***
    - Severe chronic congenital neutropenia, cyclic neutropenia, or idiopathic neutropenia
    - Drug-induced neutropenia in immunosuppressed patients
        - Patient has evidence of inadequate bone marrow reserve (e.g., recurrent fevers, splenomegaly, mucosal ulcers, abdominal pain) **OR**
        - Patient is at high risk for the development of serious bacterial infection (e.g., primarily severe neutropenia, indwelling venous catheters, prior serious infections) **OR**
        - Patient has a documented bacterial infection
    - Myeloid reconstitution after autologous or allogenic or autologous bone marrow transplant
        - Patient has a non-myeloid malignancy
    - Following reinfusion of peripheral blood stem cells (PBSCs)

- ***Peripheral blood stem cell (PBSC) mobilization***
    - Prior to and during leukapheresis in cancer patients preparing to undergo bone marrow ablation

- ***Acute radiation exposure***
    - Following exposure to myelosuppressive doses of radiation at a dose of 2gray (GY)

- ***CSFs for non-FDA approved indications*** require medical literature/clinical studies from peer-reviewed journals with safety, efficacy and dosing information for the intended use.

❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
- Medical Record which documents the FDA approved indication and Absolute neutrophil count (ANC)

❒ **Prescriber Specialty:** Prescribed by hematologist and/or oncologist, or other specialist per associated diagnosis/indication

❒ **Quantity:**
- ***Chemotherapy-induced neutropenia (primary or secondary prophylaxis):***
    - Approve per cycle of chemotherapy up to a 14 day supply
    - Include refills if number of cycles is provided
- ***Treatment of neutropenia (e.g., congenital, cyclic, or idiopathic, or after chemo + BMT):***
    - Approve for 3 months

❒ **Gender**: Male or Female

❒ **Route of Administration**: Subcutaneous

❒ **Place of Service**: Outpatient

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - ***Chemotherapy-induced neutropenia (primary or secondary prophylaxis):***
    - Recent ANC showing a response to therapy
    - Approve per cycle of chemotherapy up to a 14 day supply
    - Include refills if number of cycles is provided
  - ***All other indications:***
    - Recent ANC
    - Approve every 30 days.

Contraindications/Exclusions/Discontinuation:

- Contraindicated in patients with a history of serious allergic reactions to human granulocyte colony-stimulating factors such as filgrastim or pegfilgrastim
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- **Warnings:**
  - **Splenic rupture:** Rare cases of splenic rupture have been reported (may be fatal); in patients with upper abdominal pain, left upper quadrant pain, or shoulder tip pain, withhold treatment and evaluate for enlarged spleen or splenic rupture.[1,2]
  - **Respiratory distress syndrome:** Acute respiratory distress syndrome (ARDS) has been reported. Evaluate patients who develop fever and lung infiltrates or respiratory distress for ARDS; discontinue in patients with ARDS.[1,2]
  - **Alveolar hemorrhage:** Reports of alveolar hemorrhage, manifested as pulmonary infiltrates and hemoptysis (requiring hospitalization), have occurred in healthy donors undergoing peripheral blood progenitor cell mobilization (unlabeled for use in healthy donors); hemoptysis resolved upon discontinuation.[1]
  - **Nephrotoxicity:** Based on findings of azotemia, hematuria (micro- and macro-scopic), proteinuria, and renal biopsy, glomerulonephritis has occurred in patients receiving filgrastim. Glomerulonephritis usually resolved after filgrastim dose reduction or discontinuation. If glomerulonephritis is suspected, evaluate for cause; if likely due to filgrastim, consider dose reduction or treatment interruption.[1]
  - **Sickle cell disorders:** May precipitate severe sickle cell crises, sometimes resulting in fatalities, in patients with sickle cell disorders (sickle cell trait or sickle cell disease); carefully evaluate potential risks and benefits. Discontinue in patients undergoing sickle cell crisis.[1,2]
  - **Capillary leak syndrome:** Capillary leak syndrome (CLS), characterized by hypotension, hypoalbuminemia, edema, and hemoconcentration, may occur in patients receiving human G-CSF. CLS episodes may vary in frequency and severity. If CLS develops, monitor closely and manage symptomatically (may require intensive care). CLS may be life-threatening if treatment is delayed.[2]

- **Warnings, continued:**
  - **Hematologic effects:** WBCs of 100,000/mm^3 or more have been reported with filgrastim doses higher than 5 mcg/kg/day. When filgrastim products are used as an adjunct to myelosuppressive chemotherapy, discontinue when ANC exceeds 10,000/mm^3 after the ANC nadir has occurred (to avoid potential excessive leukocytosis). Doses that increase the ANC beyond 10,000/mm^3 may not result in additional clinical benefit. Monitor complete blood cell count (CBC) twice weekly during therapy. In patients receiving myelosuppressive chemotherapy, filgrastim discontinuation generally resulted in a 50% decrease in circulating neutrophils within 1 to 2 days, and a return to pretreatment levels in 1 to 7 days. When used for peripheral blood progenitor cell collection, discontinue filgrastim products if leukocytes greater than 100,000/mm^3. Thrombocytopenia has also been reported with filgrastim products; monitor platelet counts.[1]
  - **Severe chronic neutropenia:** Establish diagnosis of severe chronic neutropenia prior to initiation; use prior to appropriate diagnosis of severe chronic neutropenia may impair or delay proper evaluation and treatment for neutropenia due to conditions other than severe chronic neutropenia. Myelodysplastic syndrome (MDS) and acute myeloid leukemia (AML) have been reported to occur in the natural history of congenital neutropenia (without cytokine therapy). Cytogenetic abnormalities and transformation to MDS and AML have been observed with filgrastim when used to manage severe chronic neutropenia, although the risk for MDS and AML appears to be in patients with congenital neutropenia. Abnormal cytogenetics and MDS are associated with the development of AML. The effects of continuing filgrastim products in patients who have developed abnormal cytogenetics or MDS are unknown; consider risk versus benefits of continuing treatment.[1]
  - **Cytotoxic chemotherapy:** Do not use filgrastim products in the period 24 hours before to 24 hours after administration of cytotoxic chemotherapy because of the potential sensitivity of rapidly dividing myeloid cells to cytotoxic chemotherapy. Transient increase in neutrophil count is seen 1 to 2 days after filgrastim initiation; however, for sustained neutrophil response, continue until post nadir ANC reaches 10,000/mm^3.[1,2]
  - **Radiation therapy recipients:** Avoid concurrent radiation therapy with filgrastim products; safety and efficacy have not been established with patients receiving radiation therapy.[1]
  - **Tumor growth effects:** The G-CSF receptor through which filgrastim products act has been found on tumor cell lines. May potentially act as a growth factor for any tumor type (including myeloid malignancies and myelodysplasia). When used for stem cell mobilization, may release tumor cells from marrow that could be collected in leukapheresis product; potential effect of tumor cell reinfusion is unknown.[1,2]
  - **Cutaneous vasculitis:** Moderate or severe cutaneous vasculitis has been reported, generally occurring in patients with severe chronic neutropenia on long-term therapy. Withhold treatment if cutaneous vasculitis occurs; may be restarted with a dose reduction once symptoms resolve and the ANC has decreased.[1]
  - **Nuclear imaging:** Increased bone marrow hematopoietic activity due to colony-stimulating factor (CSF) use has been associated with transient bone-imaging changes; interpret results accordingly.[1]
  - **Latex:** The packaging of some dosage forms may contain latex.[1]

- **Warnings, continued:**
  - **Polysorbate 80:** Some dosage forms may contain polysorbate 80 (also known as **Tweens**). Hypersensitivity reactions, usually a delayed reaction, have been reported following exposure to pharmaceutical products containing polysorbate 80 in certain individuals.[21,23,24] Thrombocytopenia, ascites, pulmonary deterioration, and renal and hepatic failure have been reported in premature neonates after receiving parenteral products containing polysorbate 80.[20,22] See manufacturer's labeling.
  - **Appropriate use:** Filgrastim products should not be routinely used in the treatment of established neutropenic fever. CSFs may be considered in cancer patients with febrile neutropenia who are at high risk for infection-associated complications or who have prognostic factors indicative of a poor clinical outcome (eg, prolonged and severe neutropenia, older than 65 years, hypotension, pneumonia, sepsis syndrome, presence of invasive fungal infection, uncontrolled primary disease, hospitalization at the time of fever development). CSFs should not be routinely used for patients with neutropenia who are afebrile. Dose-dense regimens that require CSFs should only be used within the context of a clinical trial or if supported by convincing evidence.[7,8,27]
  - **Hypersensitivity reactions:** Serious allergic reactions (including anaphylaxis) have been reported, usually with the initial exposure; may be managed symptomatically with administration of antihistamines, steroids, bronchodilators, and/or epinephrine. Allergic reactions may recur within days after the initial allergy management has been stopped. Do not administer filgrastim products to patients who experienced serious allergic reaction to filgrastim or pegfilgrastim. Permanently discontinue filgrastim products in patients with serious allergic reactions.[1,2]
  - **Pediatric:** CSF use in pediatric patients is typically directed by clinical pediatric protocols. The American Society of Clinical Oncology (ASCO) Recommendations for the Use of WBC Growth Factors Clinical Practice Guideline Update states that CSFs may be reasonable as primary prophylaxis in pediatric patients when chemotherapy regimens with a high likelihood of febrile neutropenia are employed. Likewise, secondary CSF prophylaxis should be limited to high-risk patients. In pediatric cancers in which dose-intense chemotherapy (with a survival benefit) is used, CSFs should be given to facilitate chemotherapy administration. CSFs should not be used in the pediatric population for non-relapsed acute lymphoblastic or myeloid leukemia when no infection is present.[27]
  - **Elderly:** The ASCO Recommendations for the Use of WBC Growth Factors Clinical Practice Guideline Update recommend that prophylactic CSFs be used in patients 65 years and older with diffuse aggressive lymphoma treated with curative chemotherapy (eg, rituximab, cyclophosphamide, doxorubicin, vincristine, prednisone), especially if patients have comorbid conditions.[27]
  - **Category C for pregnancy**: warn-precautions end pregnancy-lactation start
- **Drug interactions:**
  - Bleomaycin toxicity and Cyclophosamide may be increased when used with filgrastim, especially pulmonary toxicity
  - Topotecan toxicity may be enhanced with concomitant use of filgastim

- **Drug / Lab test interactions:**
  - May interfere with bone imaging studies; increased hematopoietic activity of the bone marrow may appear as transient positive bone imaging changes.[3]

ONCOLOGY AGENTS- AS IDENTIFIED ON THE MCO COMMON FORMULARY

Drug Class: Antineoplastic Agents (unless otherwise defined by Specific Medication Criteria)

- ❒ Alkylating Agents
- ❒ Antibody Drug Complexes
- ❒ Antimetabolites
- ❒ Enzymes
- ❒ Hedgehog Pathway Inhibitor
- ❒ Hormone Antagonists
- ❒ Immunomodulators
- ❒ Immunotherapy
- ❒ Mast Stabilizers
- ❒ Metal Complexes
- ❒ Mitotic Inhibitors
- ❒ Others
- ❒ Photosensitizers
- ❒ Radiopharmaceuticals
- ❒ Retinoid
- ❒ Systemic Enzymes
- ❒ Topoisomerase Inhibitor
- ❒ Vascular Endothelial Growth Factor
- ❒ Antineoplastic Antibiotics
- ❒ Antineoplastic Combinations

FDA-approved uses: Treatment of a Cancer Diagnosis

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:** Cancer
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 3 months
  - **Continuation of Therapy:** 3 month increments
- ❒ **Prescriber Specialty:** Oncologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Proper diagnosis of an FDA Approved Indication **OR**
  - If request is for a non-FDA Approved indication, the request must be for a "medically accepted indication" as noted in the following Compendia:
    - American Hospital Formulary Drug Service (AHFS-DI)
    - NCCN Drugs and Biologic Compendium/ NCCN Guidelines
      - Categories 1, 2a, and 2b will be accepted. (See Table 1 for explanation of Categories)
    - Micromedex DrugDex
    - Clinical Pharmacology
  - Member must be under the care of an Oncologist
  - Documentation of dose and dates of all previous therapy and the resulting outcomes
  - Documentation that the proper succession of the therapies has been tried and failed (i.e. intolerance, contraindication, or progression)
  - Chart notes detailing the member's current clinical status
  - Related lab work, test results, or clinical markers supporting the diagnosis and or continuing treatment
- ❒ **Not Approved If:**
  - Patient has any contraindications to the use of any requested ingredients
  - Request is for experimental/investigational use
  - Member is enrolled in a clinical trial
- ❒ **Dosing:**
  - As noted in Package Insert
  - As noted in Above described Compendium

Criteria for continuation of therapy

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Current chart notes detailing response and compliance to therapy
  - Documented clinically significant improvements in the disease state, and stability on the medication

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to the requested agent or any component of the formulation
- Member at risk through drug-drug interactions of contraindications noted in the package insert
- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occulted after initiation of drug therapy

References:

- National Comprehensive Cancer Network® (NCCN), "Clinical Practice Guidelines in Oncology™: Available at http://www.nccn.org

NCCN Categories of Evidence and Consensus
Category 1: Based upon high-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2A: Based upon lower-level evidence, there is uniform NCCN consensus that the intervention is appropriate.
Category 2B: Based upon lower-level evidence, there is NCCN consensus that the intervention is appropriate.
Category 3: Based upon any level of evidence, there is major NCCN disagreement that the intervention is appropriate.
All recommendations are category 2A unless otherwise noted.

Table 1: NCCN Categories of Evidence and Consensus.

MONOPHASIC BRANDED ORAL CONTRACEPTIVES - AS IDENTIFIED ON THE MCO COMMON FORMULARY

Drug Class: Monophasic Oral Contraceptives

- ❒ **Generic Name:** Norethindrone acetate /ethinyl estradiol
- ❒ **Brand Name:**
  - Femcon
  - Generess
  - Layolis
  - Minastrin
  - Wymza
  - Zenchent
  - Zeosa

FDA-approved uses: Contraception

Coverage Criteria/Limitations for initial authorization

- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Proper diagnosis of an FDA Approved Indication **OR**
  - If request is for a non-FDA Approved indication, the request must be for a "medically accepted indication" as noted in the following Compendia:
    - American Hospital Formulary Drug Service (AHFS-DI)
    - Micromedex DrugDex
    - Clinical Pharmacology
  - Documentation of dose and dates of all previous therapy and the resulting outcomes
  - Documentation of failure or intolerance of 2 formulary generic alternatives
  - Documentation of need for chewable medication
- ❒ **Not Approved If:**
  - Patient has any contraindications to the use of any requested ingredients
  - Request is for experimental/investigational use
  - Member is enrolled in a clinical trial
- ❒ **Dosing:**
  - As noted in Package Insert
  - As noted in Above described Compendium

Criteria for continuation of therapy

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Current chart notes detailing response and compliance to therapy
  - Documented clinically significant improvements in the disease state, and stability on the medication

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to the requested agent or any component of the formulation
- Member at risk through drug-drug interactions of contraindications noted in the package insert
- Member is over 35 years old and smokes
- Member is having adverse events on medication
- Member has any contraindications to the use of the requested ingredients

References: http://www.accessdata.fda.gov

PROTOPIC® OINTMENT (0.03%, 0.1%) / TACROLIMUS

Drug Class: Dermatological - Calcineurin Inhibitors

FDA-approved uses: Both 0.03% and 0.1% for adults, and only 0.03% for children aged 2 to 15 years, is indicated as *second-line therapy* for the short-term and non-continuous chronic treatment of moderate to severe atopic dermatitis in non-immunocompromised adults and children who have failed to respond adequately to other topical prescription treatments for atopic dermatitis, or when those treatments are not advisable.

Available dosage forms: Ointment, 0.03%; Ointment, 0.1%

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Atopic dermatitis
- ❒ **Duration of Approval:**
  - **Initial Approval:** 1 year
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Trial, failure, or contraindication of two topical corticosteroids **OR**
  - A clinical reason why treatment with topical corticosteroids are not appropriate, including but not limited to:
    - previous inadequate response
    - skin atrophy, or
    - use on an area of the body at high risk for skin atrophy, such as the face or skin folds
- ❒ **Quantity:** 30 grams per 30 days
- ❒ **Age:**
  - **0.03% ointment** – 2 years of age and older
  - **0.1% ointment** – 16 years of age and older
- ❒ **Route of Administration:** Topical

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - The above criteria has been met
  - The prescriber deems a continued need for the requested product

Contraindications/Exclusions/Discontinuation:

- When above criteria are not met
- Tacrolimus 0.1% ointment in children less than 16 years of age
- Concurrent therapy with Elidel
- noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

PULMONARY ARTERIAL HYPERTENSION

ADCIRCA® / TADALAFIL
ADEMPAS® / RIOCIGUAT
LETAIRIS® / AMBRISENTAN
REVATIO® / SILDENAFIL
TRACLEER® / BOSENTAN

Drug Class: Pulmonary Antihypertensive Agents

FDA-approved uses:

- ❒ Adcirca: Pulmonary Arterial Hypertension (PAH), WHO Group 1
- ❒ Letairis - Pulmonary Hypertension, with WHO Group 1
- ❒ Tracleer - Pulmonary Hypertension, with WHO Group 1
- ❒ Adempas:
  - Chronic Thromboembolic Pulmonary Hypertension
  - Pulmonary Arterial Hypertension
- ❒ Sildenafil: Pulmonary Hypertension

Available dosage forms:

- ❒ ***Adcirca:** 20 mg tablet
- ❒ ***Adempas:** 0.5 mg, 1 mg, 1.5 mg, 2 mg, 2.5 mg,
- ❒ ***Letairis:** 5 mg, 10 mg tablet
- ❒ **Revatio:** 10 mg/ml Oral Suspension, 10 mg/12.5ml IV solution
- ❒ ***Sildenafil:** 20 mg tablet
- ❒ ***Tracleer:** 62.5 mg, 125 mg tablet
- ❒ **Viagra:** 25 mg, 50 mg, 100 mg Tablet

****Covered on the Managed Care Common Formulary***

Adcirca is covered for members who meet the following criteria:

Drug Class: Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhibitor

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Pulmonary Arterial Hypertension (PAH), WHO Group 1 which is symptomatic
- ❒ **Duration of approval :**
  - **Initial Authorization:** 1 year
  - **Continuation of therapy:** 1 year
- ❒ **Prescriber Specialty:** Pulmonologist or Cardiologist

Adcirca, continued

- ❒ **Documentation Requirements-** (e.g. Labs, Medical Record, Special Studies):
  (All three bullets must be met)
  - PAH defined as WHO Group 1 of pulmonary hypertension,
  - Diagnosis id confirmed using a right heart catheterization test:
    Pretreatment Right heart catheterization results:
    - MPAP≥25mmHg
    - PCWP≤15 mmHg
    - PVR > 3 Wood units
  - Member has NYHA functional Class II or III symptoms
- ❒ **Quantity:** 40 mg taken once daily; dividing the dose over the course of the day is not recommended.
- ❒ **Age:** 18 or older, safety has not been proven in children.
- ❒ **Route of Administration**: Oral
- ❒ **Place of Service:** Home

Criteria for continuation of therapy:

- ❒ Documentation of the following is required:
  - All initial authorization criteria must be met.

Contraindications/Exclusions/Discontinuation:

- Contraindicated in individuals with known hypersensitivity to tadalafil.
- Concomitant use of organic nitrated or GC stimulators
- Use cautiously with mild to moderate renal insufficiency:
  - **Mild to moderate renal insufficiency** (Cr Clearance 31-80ml/min): Initiate therapy with 20 mg daily; increase to 40 mg once daily based on individual tolerability.
  - **Severe renal insufficiency** (Cr Clearance 30ml/minor less): Avoid use
  - **End-stage renal disease requiring hemodialysis:** Avoid use
- Hepatic function Impairment:
  - **Mild or moderate hepatic impairment (Child-Pugh class A or B):** Use with caution. Consider a starting dosage of 20 mg per day.
  - **Severe hepatic cirrhosis (Child-Pugh class C):** Avoid Use
- Use cautiously with ritonavir
  - **Initiation of tadalafil in patients currently receiving ritonavir for at least 1 week:** Initiate tadalafil at 20 mg once daily; increase to 40 mg once daily based on individual tolerability.
  - **Initiation of ritonavir in patients currently receiving tadalafil:** Discontinue tadalafil at least 24 hours prior to the initiation of ritonavir. After at least 1 week of ritonavir, resume tadalafil at 20 mg once daily; increase to 40 mg once daily based on individual tolerability.
- Do not use if taking rifampin or ketoconazole
- If sudden loss of vision in one or both eyes or sudden decrease of hearing and or dizziness, patient must seek immediate medical attention.
- Prolonged erectile dysfunction, seek medical attention.

Adcirca, continued

Other special considerations:

- Tadalafil has been used off label to Raynaud's phenomenon. It may be used as monotherapy or as adjunctive therapy to vasodilator therapy (e.g. , calcium channel blockers, angiotensin receptor blockade)

Adempas is covered for members who meet the following criteria:

Drug Class: Pulmonary Antihypertensive Agents-Soluble Guanylate Cyclase Stimulator

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:**
  - Chronic thromboembolic pulmonary hypertension
  - Pulmonary arterial hypertension
- ❒ **Duration of approval :**
  - **Initial Authorization:** 1 year
  - **Continuation of therapy:** 1 year
- ❒ **Prescriber Specialty:** Pulmonologist or cardiologist

For Chronic Thromboembolic Pulmonary Hypertension (CTEPH):

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Member has CTEPH defined as WHO Group 4 of pulmonary hypertension
  - Member has one of the below:
    - Recurrent or persistent CTEPH after pulmonary endarterectomy (PEA): Documented date of pulmonary endarterectomy (PEA) for CTEPH only)
      OR
    - Inoperable CTEPH with the diagnosis confirmed by both of the following (I and II):
      - Computed tomography(CT)/Magnetic resonance imaging (MRI) angiography or pulmonary angiography
      - Pretreatment right heart catheterization with all the of the following results:
        - MPAP≥25mmHg
        - PCWP≤15 mmHg
        - PVR > 3 Wood units

For Pulmonary Arterial Hypertension (PAH)

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Member has PAH defined as WHO Group 1 of pulmonary hypertension.
  - PAH confirmed by right heart catheterization with the following pretreatment results:
    - MPAP≥25mmHg
    - PCWP≤15 mmHg
    - PVR > 3 Wood units
  - Member has NYHA functional Class II or III symptoms prior to initiation of Adempas therapy.

Adempas, continued

- ❒ **Quantity:** 2.5 mg three times daily, maximum. Initial dosage is 1mg TID. Or 0.5mg TID for individuals unable to tolerate the hypotensive effects. Titration may increase by 0.5 mg TID if systolic blood pressure remains greater that 95 mmHG and the patient has no signs or symptoms of hypotension. Dose increase should be no sooner than 2 weeks apart. May decrease the dose by 0.5 mg three times daily if the hypotensive effects are not tolerated
- ❒ **Age:** 18 or older, pediatric safety and effectiveness have not been established
- ❒ **Route of Administration**: Oral
- ❒ **Place of Service:** Outpatient/home

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - All members requesting continuation of therapy must meet all initial authorization criteria.

Contraindications/Exclusions/Discontinuation:

- **Boxed Warning:** Embryo-fetal toxicity. All female patient obtain Riociguat through a restricted program called the Adempas risk evaluation and mitigation strategy (REMS) program. Obtain pregnancy tests in female patients prior to initiation and monthly during treatment. **Category X**
- Co-administration with nitrates or nitric oxide donors (e.g., amyl nitrite) in any form
- Co-administration with phosphodiesterase (PDE) inhibitors, including specific PDE-5 inhibitors (e.g., sildenafil, tadalafil, vardenafil) or nonspecific PDE inhibitors (e.g., dipyridamole or theophylline)
- Concomitant therapy: Strong cytochrome P450 and P-glycoprotein/breast cancer resistance protein inhibitors (e.g. azole antifungals [such as ketoconazole, itraconazole], or protease inhibitors. [e.g. ritonavir])
- Renal function impairment: No dosage adjustment provided in manufacturer's labeling.
- Hepatic function impairment: (Child-Pugh A, B, and C) No dosage adjustment provided in the manufacturer's labeling

Other special considerations:

- **Smokers:**
  - Consider titrating to greater than 2.5 mg three times daily, if tolerated. A decreased dose may be necessary in patients who stop smoking during therapy.

  REMS program: Call 1-855-423-3672 or visit http://www.AdempasREMS.com for more information.
- **Hypotension:** Reduces blood pressure. Use with caution in patients at increased risk for symptomatic hypotension or ischemia (eg, patients with hypovolemia, severe left ventricular outflow obstruction, resting hypotension, autonomic dysfunction) or concurrent use of antihypertensives or strong CYP-450 and P-glycoprotein/breast cancer resistance protein inhibitors. Consider initiating at a lower dose for patients at risk of hypotension and/or dose reduction if hypotension develops.

Adempas, continued

Other special considerations: continued

- **Bleeding:** Serious bleeding has been observed.
- **Pulmonary veno-occlusive disease:** Use is not recommended in patients with pulmonary veno-occlusive disease. Discontinue in any patient with pulmonary edema suggestive of pulmonary veno-occlusive disease.
- **CNS effects:** Patients must be cautioned about performing tasks that require mental alertness (e.g., operating machinery or driving).
- **Hazardous agent:** Use appropriate precautions for handling and disposal (meets NIOSH 2014 criteria).

Letairis is covered for members who meet the following criteria:

Drug Class: Pulmonary Antihypertensive Agents - Endothelin Receptor Antagonists

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Diagnosed with primary pulmonary hypertension **OR** secondary pulmonary hypertension due to scleroderma, sclerosis or autoimmune disease by a Pulmonologist or Cardiologist
- ❒ **Duration of approval:**
  - **Initial Authorization:** 4 months
  - **Continuation of therapy:** 1 year
- ❒ **Prescriber Specialty:** Pulmonologist or cardiologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - WHO Group I with NYHA functional class II or III
  - Patient has received adequate treatment trial with anticoagulants +/- diuretics +/- digoxin
  - Acute vasoreactivity testing result:
    - For patients with positive testing result, documentation of a trial and failure with calcium channel blocker therapy, unless it is contraindicated, such as those with right heart failure or hemodynamic instability
      OR
    - For patients with negative testing result, calcium channel blocker is not indicated
- ❒ **Age:** > 18 years of age
- ❒ **Route of Administration**: Oral

Criteria for continuation of therapy:

- ❒ **Documentation of the following is required:**
  - Stabilization or improvement in functional status (NYHA functional class), **or**
  - Improvement in PAP or other measures of pulmonary hypertension

Letairis, continued

Contraindication/Exclusion/Discontinuation:

- **Boxed Warning: Pregnancy:** Do not administer ambrisentan to a pregnant woman because it may cause fetal harm. Ambrisentan is very likely to produce serious birth defects is used by pregnant women because this effect has been seen consistently when it is administered to animals. Therefore, pregnancy must be excluded before the initiation of treatment. Females of reproductive potential must use acceptable methods of contraception during treatment and for 1 month after treatment. Obtain monthly pregnancy tests during treatment and 1 month after discontinuation.
- Hypersensitivity to any product
- Idiopathic pulmonary fibrosis, including idiopathic pulmonary fibrosis patients with pulmonary hypertension (WHO group 3)
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Sildenafil is covered for members who meet the following criteria:

Drug Class: Pulmonary Antihypertensive Agents - Selective c-GMP PDE Type 5 Inhibitor

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Pulmonary Arterial Hypertension, WHO Group I with symptoms
- ❒ **Duration of approval :**
  - **Initial Authorization:** 1 year
  - **Continuation of therapy:** 1 year
- ❒ **Prescriber Specialty:** Pulmonologist or Cardiologist
- ❒ **Documentation Requirements-** (e.g. Labs, Medical Record, Special Studies):
  - Report with pretreatment results from right heart catheterization:
    - Member has PAH defined as WHO Group 1 of pulmonary hypertension
    - PAH was confirmed by one of the below:
      - Pretreatment right heart catheterization with all of the following results:
        - mPAP≥ 25 mmHG
        - PCWP ≤ mmHG
        - PVR > Wood units

        OR
      - For infants less than one year of age with any of the following conditions, PAH was confirmed by Doppler echocardiogram if right heart catheterization cannot be performed:
        - Post cardiac surgery
        - Chronic Heart Disease
        - Chronic lung disease associated with prematurity
        - Congenital diaphragmatic hernia
    - Member has NYHA functional Class II or III symptoms
- ❒ **Age:** Adults only, not recommended for use in children
- ❒ **Route of Administration**: Oral-tablet or suspension

Sildenafil, continued

- ❒ **Place of Service:** Outpatient /Home
- ❒ **Dosage:** Use of Revatio, especially long term, is not recommended for children. If used in children, must use cautiously. After 2 years of treatment, increased mortality seen in long-term use at higher doses (20-80 mg-weight dependent):
    - For members who are <18 years of age (tablets or suspension): maximum 30 mg per day
    - For members who are ≥ 18 years of age (tablets only):
        - For initial therapy: maximum 60 mg per day
        - For continuation of therapy: maximum 240 mg per day for members who have been titrated without difficulty and have clinically benefited.

Criteria for continuation of therapy:

- ❒ Documentation of the following is required:
    - All initial authorization criteria must be met.

Contraindications/Exclusions/Discontinuation:

- ❒ Use of organic nitrates medication (e.g. Nitroglycerin, isosorbide dinitrate) on a regular or intermittent basis is contra-indicated.
- ❒ Concomitant treatment with guanylate cyclase stimulator (e.g. Adempas) is contraindicated.
- ❒ Hypersensitivity reaction to this product.

Other special considerations:

- **Renal function impairment**: No dosage adjustment required for any degree of impairment.
- **Hepatic function impairment**: No need for dosage adjustment for mild to moderate impairment, has not been studied in patient with severe impairment.
- **Cardiovascular disease:** Use cautiously in patient with hypotension; uncontrolled hypertension, life-threatening arrhythmias, stoke or MI within the last 6 months and other cardiac conditions.
- Not recommended in patient with pulmonary veno-occlusive disease.
- Risk of hearing loss, color discrimination, vision loss.
- Safety in patients with sickle cell anemia, a bleeding disorder or peptic ulcer disease has not been established.

Tracleer is covered for members who meet the following criteria:

Drug Class: Pulmonary Antihypertensive Agents - Endothelin Receptor Antagonists

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Diagnosed with primary pulmonary hypertension OR secondary pulmonary hypertension due to scleroderma, sclerosis or autoimmune disease by a Pulmonologist or Cardiologist
- ❒ **Duration of approval:**
  - **Initial Authorization:** 4 months
  - **Continuation of therapy:** 1 year
- ❒ **Prescriber Specialty:** Pulmonologist or cardiologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - WHO Group I
  - NYHA functional class II, III or IV
  - Has received adequate treatment trial with anticoagulants +/- diuretics +/- digoxin
  - Acute vasoreactivity testing result:
    - For patients with a positive testing result, documentation of a trial and failure with calcium channel blocker therapy is required, unless it is contraindicated, such as those with right heart failure or hemodynamic instability.
      OR
    - For patients with a negative testing result, calcium channel blocker therapy is not indicated
- ❒ **Age:** > 18 years of age
- ❒ **Route of Administration**: Oral

Criteria for continuation of therapy:

- ❒ Documentation of the following is required:
  - Stabilization or improvement in functional status (NYHA functional class), or
  - Improvement in PAP or other measures of pulmonary hypertension

Contraindications/Exclusions/Discontinuation:

- **Boxed Warning: Pregnancy**- Do not administer ambrisentan to a pregnant woman because it may cause fetal harm. Ambrisentan is very likely to produce serious birth defects if used by pregnant women because this effect has been seen consistently when it is administered to animals. Therefore, pregnancy must be excluded before the initiation of treatment. Females of reproductive potential must use acceptable methods of contraception during treatment and for 1 month after treatment. Obtain monthly pregnancy tests during treatment and 1 month after discontinuation.
- Hypersensitivity to any product
- Drug interaction specific to Bosentan: concomitant use with cyclosporine A or glyburide
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Appendix A: WHO Classification of Pulmonary Hypertension

The World Health Organization divides pulmonary hypertension (PH) into five groups. These groups are organized based on the cause of the condition.
Note that group 1 is called pulmonary arterial hypertension (PAH) and groups 2 through 5 are called pulmonary hypertension. However, together all groups are called pulmonary hypertension.

Group 1 Pulmonary Arterial Hypertension (PAH) includes:

- Idiopathic -PAH that has no known cause.
- Heritable - PAH that's inherited (passed from parents to children through genes).
- Drug and Toxin induced -PAH that's caused by drugs or toxins, such as street drugs and certain diet medicines.
- PAH that's caused by conditions such as:
    - Connective tissue diseases
    - HIV infection
    - Liver disease
    - Congenital heart disease
    - Sickle cell disease
    - Schistosomiasis
- PAH that's caused by conditions that affect the veins and small blood vessels of the lungs.

Group 2 Pulmonary Hypertension with Left Heart Disease

- Conditions that affect the left side of the heart, such as:
    - Mitral valve disease
    - Long term high blood pressure

Group 3 Pulmonary Hypertension associate with Lung Diseases such as:

- Chronic obstructive pulmonary disease (COPD)
- Interstitial lung diseases
- Pulmonary Hypertension associated with sleep-related breathing disorders, such as

Group 4 Chronic Thromboembolic Pulmonary Hypertension (CTEPH) includes:

- PH caused by blood clots in the lungs
- PH caused by blood clotting disorders

Group 5 Pulmonary Hypertension caused by various other diseases or conditions:

- Blood disorders such as:
    - Polycythemia vera
    - Essential thrombocythemia
- Systemic disorders, such as:
    - Sarcoidosis
    - Vasculitis
- Metabolic disorders, such as:
    - Thyroid disease
    - Glycogen storage disease
- Other conditions, such as:
    - Tumors that press on the pulmonary arteries
    - Kidney disease

Appendix B: New York Heart Association Functional Classification

- **Class I:** Patients with cardiac disease but without resulting limitation of physical activity. Ordinary physical activity does not cause undue fatigue, palpitation, dyspnea, or anginal pain.
- **Class II:** Patients with cardiac disease resulting in slight limitation of physical activity. They are comfortable at rest. Ordinary physical activity results in fatigue, palpitation, dyspnea, or anginal pain.
- **Class III:** Patients with cardiac disease resulting in marked limitation of physical activity. They are comfortable at rest. Less than ordinary activity causes fatigue, palpitation, dyspnea, or anginal pain.
- **Class IV:** Patients with cardiac disease resulting in inability to carry on any physical activity without discomfort. Symptoms of heart failure or the anginal syndrome may be present even at rest. If any physical activity is undertaken, discomfort is increased.

REFERENCES:

1) The Criteria Committee of the New York Heart Association. *Nomenclature and Criteria for Diagnosis of Diseases of the Heart and Great Vessels*. 9th ed. Boston, Mass: Little, Brown & Co; 1994:253-256.

2) "Types of Pulmonary Hypertension" (2011, August 2). Retrieved from http://www.nhlbi.nih.gov/health/health-topics/topics/pah/

PULMOZYME® / DORNASE ALPHA

Drug Class*:* Mucolytics

FDA-approved uses:

- ❒ In conjunction with standard therapies for the management of cystic fibrosis (CF) patients to improve pulmonary function.
- ❒ To reduce the risk of respiratory tract infections requiring parenteral antibiotics in CF patients with an FVC ≥ 40% of predicted.

Available dosage forms: 2.5 mg/2.5 mL in single-use ampules

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** cystic fibrosis
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 1 year
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Medical records to support a diagnosis of CF
  - Baseline FVC
  - Documentation to support inadequate response or intolerance to inhaled hypertonic saline (required for mild cystic fibrosis only) **OR** evidence of frequent respiratory tract infections
    - **Mild Cystic Fibrosis = FEV1 of 70-89%**
    - **Moderate to Severe Cystic Fibrosis = FEV1 of ≤ 69%**
- ❒ **Prescriber Specialty:**
  - Pulmonologist
  - Infectious disease
- ❒ **Quantity:** 30 ampules per 30 days
- ❒ **Age:** at least 5 years of age
- ❒ **Gender:** male or female
- ❒ **Route of Administration:** inhalation
- ❒ **Place of Service*:*** outpatient

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - FVC
  - Medical records showing stable disease
  - Medical records supporting decreased incidence of respiratory infections

Contraindications/Exclusions/Discontinuation:

- Pulmozyme® (dornase alpha) is not authorized for non-FDA-approved indication
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Per FDA-approved label: Pulmozyme® (dornase alpha) was studied in patients 3 months to 5 years of age; while clinical trial data are limited in patients <5 years, the use of Pulmozyme® (dornase alpha) should be considered for pediatric patients with CF who may experience potential benefit in pulmonary function or who may be at risk of respiratory tract infection.

RENVELA® / SEVELAMER

Drug Class: Phosphate binders

FDA-approved uses: Indicated for the control of serum phosphorus in patients with chronic kidney disease on dialysis

Available dosage forms: Tablets: 800 mg, Powder: 0.8 g and 2.4 g packet

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Chronic kidney disease on dialysis
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, and Special Studies):
  - Hyperphosphatemia
  - Trial and failure of calcium acetate (elevated phosphorous or calcium levels for consecutive measurements)
  - Inability to swallow tablets
- ❒ **Prescriber Specialty:** Nephrologist
- ❒ **Age:** Not for pediatric use

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Labs: Serum Phosphorus

Contraindications/Exclusions/Discontinuation:

- Bowel obstruction.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

SANDOSTATIN® / OCTREOTIDE

Drug Class: Somatostatic Agents

FDA-approved uses:

- ❒ **Acromegaly**
  Octreotide Acetate Injection is indicated to reduce blood levels of growth hormone and IGF-I (somatomedin C) in acromegaly patients who have had inadequate response to or cannot be treated with surgical resection, pituitary irradiation, and bromocriptine mesylate at maximally tolerated doses.
- ❒ **Carcinoid Tumors**
  Octreotide Acetate Injection is indicated for the symptomatic treatment of patients with metastatic carcinoid tumors where it suppresses or inhibits the severe diarrhea and flushing episodes associated with the disease.
- ❒ **Vasoactive Intestinal Peptide Tumors (VIPomas)**
  Octreotide Acetate Injection is indicated for the treatment of the profuse watery diarrhea associated with VIP-secreting tumors.

Available dosage forms: Vial 50 mcg/mL, 100 mcg/mL, 200 mcg/mL, 1000 mcg/mL

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:**
  - Acromegaly
  - Metastatic VIP
  - Chemo/radiation
  - HIV/AIDS-induced diarrhea
  - Metastatic carcinoid tumors
  - Carcinoid tumors
- ❒ **Duration of Approval:**
  - **Initial Authorization**: 6 months
  - **Continuation of Therapy**: 1 year
- ❒ **Prescriber Specialty:** Prescribed by, or in consultation with, an endocrinologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Diagnosis confirmed
  - Prescribed by, or in consultation with, an endocrinologist
- ❒ **Age:** 18 years of age or older
- ❒ **Route of Administration:** Subcutaneous, intramuscular injection

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - The above criteria has been met
  - Requires decreased or normalized IGF-1 levels

Contraindications/Exclusions/Discontinuation:

- When above criteria are not met
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

SENSIPAR® / CINACALCET

Drug Class: Calcimimetic, Parathyroid Calcium Receptor Sensitivity Enhancer

FDA-approved uses:

- ❒ **Hyperparathyroidism, primary:** Treatment of severe hypercalcemia in adult patients with primary hyperparathyroidism for who parathyroidectomy would be indicated on the bases of serum calcium levels, but who are unable to undergo parathyroidectomy.
- ❒ **Hyperparathyroidism, secondary:** Treatment of secondary hyperparathyroidism in adult patients with chronic kidney disease (CKD) on dialysis.
- ❒ **Limitation of use:** Not indicated for use in patients with CKD who are not on dialysis (due to increased risk of hypocalcemia)
- ❒ **Parathyroid carcinoma**: Treatment of hypercalcemia in adult patients with parathyroid carcinoma.

Available dosage forms: Tablet 30 mg, 60 mg, 90 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA Approved Indication as listed above
- ❒ **Duration of Approval:**
  - **Initial Approval:** 6 months
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:** Nephrologist or Endocrinologist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - **For Secondary hyperparathyroidism due to CKD on dialysis**:
    - trial, failure, or intolerance to phosphate binders: calcium carbonate **AND** sevelamer
  - **Labs:**
    - iPTH, calcium, renal function, serum phosphorus. iPTH levels must be > 300 (biPTH >160) and Ca > 8.4 in order to initiate therapy.

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - iPTH > 150 pg/ml and calcium must be greater than 8.4

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to any components of Sensipar
- Hypocalcemia
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

SGLT-2 INHIBITOR
INVOKANA® / CANAGLIFLOZIN
FARXIGA® / DAPAGLIFLOZIN

COMBINATION SGLT-2 INHIBITOR
INVOKAMET® / CANAGLIFLOZIN-METFORMIN

Drug Class: Antihyperglycemic – SGLT-2 Inhibitor & Biguanide Combination

FDA-approved uses:

Single Ingredient SGLT-2 Inhibitor

Type 2 diabetes mellitus: Treatment of type 2 diabetes mellitus (noninsulin dependent) as an adjunct to diet and exercise to improve glycemic control

Combination SGLT-2 Inhibitor

Type 2 diabetes mellitus: As an adjunct to diet and exercise to improve glycemic control in adults with type 2 diabetes mellitus (non-insulin dependent NIDDM) who are not adequately controlled on a regimen containing metformin or canagliflozin, or in patients who are already treated with both canagliflozin and metformin.

Available dosage forms:

Single Ingredient Products

- ❒ Invokana Tablet 100 mg, 300 mg
- ❒ Farxiga Tablet 5 mg, 10 mg

Combination Ingredient Product

- ❒ Invokamet Tablet 50 mg/500 mg, 150 mg/500 mg, 50 mg/1000 mg, 150 mg/1000 mg

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:** FDA Approved Indication as listed above
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 6 months
  - **Continuation of Therapy:** 6 months
- ❒ **Age:** ≥ 18 years of age

Single Ingredient SGLT-2 Inhibitor

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Trial, failure or intolerance to Metformin + formulary sulfonylurea, TZD or DPP-4 agent in the past 120 days
  - A1C must be less than or equal to 9

Coverage Criteria/Limitations for initial authorization, continued

Combination SGLT-2 Inhibitor

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Clinically document successful treatment with individual components of the product for at least 60 of the most recent 120 days
  - A1C must be less than or equal to 9

Criteria for continuation of therapy:

Single Ingredient SGLT-2 Inhibitor

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Patient responding to treatment
  - Patient tolerating treatment
  - eGFR must be greater than 45ml/min/1.73m^2

Combination SGLT-2 Inhibitor

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Patient responding to treatment
  - Patient tolerating treatment

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to canagliflozin or any component of the formulation;
- Severe renal impairment (eGFR < 30 ml/minute/1.73m^2)
- End-stage renal disease
- Patient on dialysis
- In addition, therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

SOLARAZE® / DICLOFENAC

Drug Class: Dermatological - Antineoplastic or Premalignant Lesions - NSAID's

FDA-approved uses: Actinic Keratoses

Available dosage forms: 3% Gel

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Actinic Keratoses
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 3 months
  - **Continuation of Therapy:** 3 months
- ❒ **Prescriber Specialty**: Dermatology
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - An inadequate response or intolerance to office-based treatments (liquid nitrogen cryotherapy, surgical curettage) **OR** have been considered and ruled out due to nature/number of lesions or limited resources to provide such treatments; **AND**
  - An inadequate response to a full treatment or intolerance/contraindication to a trial of 5-fluorouracil; **AND**
  - An inadequate response to a full treatment or intolerance/contraindication to a trial of imiquimod
- ❒ **Quantity:** 100gm
- ❒ **Route of Administration**: For Topical Use Only

Criteria for continuation of therapy:

- ❒ Requires a positive response to therapy

Contraindications/Exclusions/Discontinuation:

- Solaraze is contraindicated in patients with a known hypersensitivity to diclofenac. Solaraze should be used with caution in patients with active GI ulceration or bleeding and severe renal or hepatic impairments.
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy OR no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations: Pregnancy Category B

SORIATANE® / ACITRETIN

Drug Class: Dermatological - Antipsoriatic Agents Systemic, Vitamin A Derivatives

FDA-approved uses: Severe Psoriasis

Available dosage forms: Capsules 10 mg, 17.5 mg, 25 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Moderate to Severe Psoriasis
- ❒ **Duration of Approval:**
  - **Initial Authorization:** 3 months
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - 90 day trial of methotrexate **AND**
  - 90 day trial of high dose topical steroid (e.g. betamethasone augmented, clobetasol, halobetasol)
- ❒ **Prescriber Specialty:** Dermatology
- ❒ **Quantity:** Max 2 capsules per day
- ❒ **Route of Administration:** Oral

Criteria for continuation of therapy

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Requires a positive response to therapy

Contraindications/Exclusions/Discontinuation:

- Soriatane must not be used by females who are pregnant, or who intend to become pregnant during therapy or at any time for at least 3 years following discontinuation of therapy.
- Soriatane is contraindicated in patients with impaired liver or kidney function and in patients with chronic abnormally elevated blood lipid values.
- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Pregnancy Category X.
- Soriatane should not be taken with methotrexate or tetracyclines.
- Soriatane should not be used in patients with known alcohol abuse.

SYNAGIS® / PALIVIZUMAB

Drug Class: Immunological Agent/Monoclonal Antibody

FDA-approved uses: Prevention of RSV for children <2yo at high risk of RSV disease
Respiratory syncytial virus (RSV) prophylaxis with palivizumab (Synagis®) **may be considered medically necessary** in the following infants and children **to a maximum of five monthly doses**:

- ❒ **Prematurity:**
  - Infants who are younger than 12 months of age at the start of RSV season and are born before **29 weeks 0 days** gestation.
- ❒ **Chronic Lung Disease (CLD):**
  - Preterm infants younger than 12 months of age who develop CLD of prematurity (defined as gestational age <32 weeks, 0 days) and required >21% oxygen for at least the first 28 days after birth.
  - Infants between 12 and 24 months of age who developed CLD of prematurity as defined above and who continue to require medical support (chronic corticosteroid therapy, diuretic therapy, supplemental oxygen or bronchodilator therapy) within 6 months of the start of RSV season.
- ❒ **Heart Disease:**
  - Infants who are 12 months of age or younger with hemodynamically significant Congenital Heart Disease (CHD). Those children with CHD who are most likely to benefit from immunoprophylaxis include those with:
    - acyanotic heart disease who are receiving medication to control congestive heart failure (documentation required) and will require cardiac surgical procedures ; **or**
    - moderate to severe pulmonary hypertension; **or**
    - cyanotic heart disease (if recommended by a pediatric cardiologist).
  - Additionally, children younger than 24 months who undergo cardiac transplantation during the RSV season may be considered for prophylaxis.
- ❒ Immune prophylaxis for RSV **is considered not medically necessary** for
  - Infants and children with hemodynamically insignificant heart disease including but not limited to:
    - secundum atrial septal defect,
    - small ventricular septal defect,
    - pulmonic stenosis,
    - uncomplicated aortic stenosis,
    - mild coarctation of the aorta,
    - patent ductus arteriosus
    - Lesions adequately corrected by surgery unless they continue to require medication for congestive heart failure.
    - Infants with mild cardiomyopathy who are not receiving medical therapy for the condition.

***Note**: Because a mean decrease in palivizumab serum concentration of 58% was observed after surgical procedures that involve cardiopulmonary bypass, for children who are receiving prophylaxis and who continue to require prophylaxis after a surgical procedure, a post-operative dose of palivizumab (15mg/kg) should be considered after cardiac bypass or at the conclusion of extra-coporeal membrane oxygenation for infants and children younger than 24 months*.

- ❒ **Neuromuscular disease, congenital airway anomaly or pulmonary abnormality**
  - Infants under 12 months of age with neuromuscular disease, congenital anomalies of the airway or pulmonary abnormalities that impair the ability to clear secretions from the upper airway because of ineffective cough.
- ❒ **Immunocompromised**
  - Infants and children, who are 24 months of age or younger, who are profoundly immunocompromised because of chemotherapy or other conditions during the RSV season.

Available dosage forms: Solution: 50 mg/0.5 ml vial, 100 mg/ml vial for IM injection

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Medically necessary FDA-approved uses as listed above
- ❒ **Duration of Approval**
  - **Initial Approval:** Maximum of 5 doses or thru the end of the RSV season, whichever comes first. Typically RSV season is November 1-March 31. This must be confirmed on an annual basis.
  - **Continuation of Therapy:** Considered in a case by case basis by each plan.
    If any infant or young child receiving monthly Synagis prophylaxis experiences a breakthrough RSV hospitalization, monthly prophylaxis should be discontinued because of the extremely low likelihood of a second RSV hospitalization in the same season (<0.5%).

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Infants who are younger than 12 months of age at the start of the Synagis season and who are born before 29 weeks, 0 days' gestation.
  - Infants in the first 12 months of life, who are diagnosed with CLD (chronic lung disease) of prematurity defined as birth at <32 weeks, 0 days' gestation and a requirement for >21% oxygen for at least 28 days after birth.
  - Infants in the second year of life who are diagnosed with CLD (as per above criteria) **AND** who continue to require medical intervention (supplemental oxygen, chronic corticosteroid, or diuretic therapy) within the 6-month period before the start of the second RSV season.
  - Children who are 12 months or younger with hemodynamically significant CHD as evidenced by:
    - acyanotic heart disease and are receiving medication to control congestive heart failure, and will require cardiac surgical procedures

- ❒ **Documentation Requirements continued** (e.g. Labs, Medical Record, Special Studies):
    - Infants with moderate to severe pulmonary hypertension. Children with pulmonary abnormality or neuromuscular disease that impairs the ability to clear secretions from the upper airways may be considered for prophylaxis in the first year of life.
    - Child younger than 24 months who will be profoundly immunocompromised during the RSV season.
- ❒ **Quantity:**
    - The recommended dose of Synagis is 15mg/kg body weight administered intramuscularly. Because 5 monthly doses of palivizumab at 15 mg/kg per dose will provide more than 6 months (>24 weeks) of serum palivizumab concentrations above the desired level for most children, administration of more than 5 monthly doses is not recommended within the continental United States. For qualifying infants who require 5 doses, a dose beginning in November and continuation for a total of 5 monthly doses will provide protection for most infants through April and is recommended for most areas of the United States. If prophylaxis is initiated in October, the fifth and final dose should be administered in February, which will provide protection for most infants through March. Qualifying infants born during the RSV season may require fewer doses.
- ❒ **Age:** 24 months and younger, See criteria for authorization for age specific indications.
- ❒ **Route of Administration:** Intramuscular

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Requests for coverage outside of RSV season will require authorization.

Contraindications/Exclusions/Discontinuation:

- History of severe prior reaction to palivizumab or any component of the formulation.
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Routine use in cystic fibrosis and Down Syndrome is not recommended.
- The clinical reviewer, in his or her professional judgment, will override criteria when the requested item is medically necessary. In addition, because there is no definite evidence for the treatment of patients undergoing stem cell transplant or infants and children with Cystic Fibrosis, the approval of Synagis for these patients will be done on a case by case basis by the clinical reviewer.

References

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4. Synagis. In:DRUGDEX® System [Internet database]. Greenwood Village, CO: Thomson Micromedex. Updated periodically. Available from: http://www.micromedex.com/.

TANZEUM® / ALBIGLUTIDE

Drug Class: Glucagonlike peptide-1 (GLP-1) receptor agonist.

FDA-approved uses: Type 2 diabetes mellitus: Adjunct to diet and exercise to improve glycemic control in the treatment of type 2 diabetes mellitus (noninsulin dependent).

Available dosage forms: Pen Injector: 30 mg & 50 mg once weekly
May increase to 50 mg once weekly if glycemic response is inadequate

Concomitant therapy:
Consider reducing the dosage of concomitantly administered insulin secretagogues (e.g., sulfonylureas) or insulin to reduce the risk of hypoglycemia when initiating albiglutide.

Renal function impairment:
No dosage adjustment necessary.
Use caution when initiating or escalating doses.

Hepatic function impairment:
There are no dosage adjustments provided in the manufacturer's labeling (has not been studied); however, changes in hepatic function are not likely to have an effect on elimination.
Do not administer intravenously or intramuscularly.

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA Approved Indication as listed above
- ❒ **Duration of Approval**
  - **Initial Approval:** 6 months
  - **Continuation of Therapy:** 6 months
- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Trial, failure or intolerance to at least two (2) antidiabetic agents such as:
    - metformin
    - sulfonylurea
    - TZD
    - DPP-4 Inhibitor
    - SGLT-2 inhibitor, **OR**
    - insulin and has not achieved adequate glycemic control (HbA1c > 7% after 3 continuous months of receiving maximal daily doses) despite current treatment
  - Chart notes confirming all previous antidiabetic therapy; medications tried, dates of trial, response to therapy.
  - A1c lab < 10%.
- ❒ **Age:** ≥ 18 years of age

Criteria for continuation of therapy:

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Patient tolerating and responding to treatment

Contraindications/Exclusions/Discontinuation:

- Not approved for convenience or if noncompliant with therapies
- HbA1c < 7.0%
- Type 1 diabetes
- Hypersensitivity or contraindications to the use of liraglutide
- Presence of medullary thyroid carcinoma; personal or family history
- Presence of multiple endocrine neoplasia syndrome type2
- Excluded if primarily being used for weight loss
- **Black Box Warning**: Albiglutide is contraindicated in patients with a personal or family history of Medullary thyroid carcinoma MTC) or in patients with Multiple Endocrine neoplasia syndrome type 2 (MEN 2). Counsel patients regarding the potential risk of MTC with the use of albiglutide and inform them of the symptoms of thyroid tumors (e.g., mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound monitoring is of uncertain value for early detection of MTC in patients treated with albiglutide.
- **Pancreatitis:** Cases of acute pancreatitis have been reported; monitor for signs and symptoms of pancreatitis (e.g., persistent severe abdominal pain that may radiate to the back and may or may not be accompanied by vomiting). If pancreatitis is suspected, discontinue use. Do not resume unless an alternative etiology of pancreatitis is confirmed. Consider antidiabetic therapies other than albiglutide in patients with a history of pancreatitis.
- **GI disease:** Use is not recommended in patients with preexisting severe GI disease.

Appropriate use:

- **Diabetes mellitus:** Not recommended for first-line therapy in patients inadequately controlled on diet and exercise alone. Do not use in patients with type 1 diabetes mellitus or for the treatment of diabetic ketoacidosis; not a substitute for insulin.
- **Patient education:** Diabetes self-management education (DSME) is essential to maximize the effectiveness of therapy.
- **Drug-drug interactions:** Potentially significant interactions may exist, requiring dose or frequency adjustment, additional monitoring, and/or selection of alternative therapy. Co
- **Insulin:** Concomitant use of insulin may increase the risk of hypoglycemia; dosage reduction of insulin may be required. Concurrent use with prandial insulin therapy has not been evaluated.
- **Insulin secretagogues:** Concomitant use of an insulin secretagogue (e.g., sulfonylurea) may increase the risk of hypoglycemia; dosage reduction of secretagogues may be required.
- **Oral medications:** Due to its effects on gastric emptying, albiglutide may reduce the rate and extent of absorption of orally administered drugs; use with caution in patients receiving medications with a narrow therapeutic window or that require rapid absorption from the GI tract.
- **Hypersensitivity reactions:** Serious hypersensitivity reactions, including pruritus, rash, and dyspnea, have been reported with use; discontinue therapy in the event of a hypersensitivity reaction; treat appropriately and monitor patients until signs and symptoms resolve.
- **Renal function impairment:** Use with caution in patients with renal impairment, particularly during initiation of therapy and dose escalation. Acute renal failure and chronic renal failure exacerbation (sometimes requiring hemodialysis) have been reported; some cases have been reported in patients with no known preexisting renal disease. Reports primarily occurred in patients with nausea/vomiting/diarrhea or dehydration.

Other special considerations:

- **REMS program: http://www.tanzeumrems.com**
  The FDA-approved REMS program includes a Communication Plan to inform prescribers of the risks of albiglutide therapy, and assessments the company must submit to the FDA. Information on the REMS program can be found at http://www.tanzeumrems.com/, and the phone number for the GlaxoSmithKline Response Center is 888-825-5249.
  Purpose: To increase awareness of potential risks of albiglutide therapy including medullary thyroid cancer and pancreatitis, and the need to avoid albiglutide use in those with a personal or family history of medullary thyroid carcinoma, and patients with endocrine neoplasia syndrome type 2.

TECFIDERA® / DIMETHYL FUMARATE

Drug Class: Multiple Sclerosis Agent - Others

FDA-approved uses: treatment of patients with relapsing forms of multiple sclerosis

Available dosage forms: Capsules 120 mg and 240 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Indicated for the treatment of patients with relapsing forms of multiple sclerosis including:
  - Relapsing-remitting multiple sclerosis [RRMS]
  - Secondary-progressive multiple sclerosis [SPMS] with relapses
  - Progressive-relapsing multiple sclerosis [PRMS]
- ❒ **Duration of Approval:**
  - **Initial Approval:** 1 year
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:**
  - Board-certified Neurologist
  - Board-certified Multiple Sclerosis physician specialist
  - Consult with a Board-certified neurologist or physician specialist with experience in prescribing multiple sclerosis therapy (submit consultation notes)
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - A definitive diagnosis of a relapsing form of multiple sclerosis as defined by the McDonald criteria.
  - Expanded Disability Status Scale (EDSS) score between 0 and 5 (disability severe enough to impair full daily activities) **OR** documentation supporting the disability within this range
  - Documented inadequate response (to at least 6 months of therapy), intolerance, FDA labeled contraindication, or hypersensitivity to an interferon beta product (Avonex®, Rebif®, Betaseron®, or Extavia®) **AND** a non-interferon, glatiramer acetate (Copaxone®).
    - **NOTE:** "Needle phobia" or "needle fatigue" is not considered an intolerance or contraindication to the first-line disease-modifying therapies (DMT's)
    - Inadequate response is defined as meeting **TWO** of the following three criteria during treatment with one of these agents: [TWO]
      - Increase in frequency (at least two clinical relapses within the past 12 months), severity and/or sequelae of relapses
      - Changes in MRI: continues to have CNS lesion progression as measured by MRI (increased number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions and/or T1 hypointense lesions)
      - Increase in disability progression: Sustained worsening of EDSS score, routine neurological observation, mobility, **or** ability to perform activities of daily living

- ❒ **Documentation Requirements, continued** (e.g. Labs, Medical Record, Special Studies):
    - Confirmation of **ONE** of the following from the Prescriber **AND** by verifying in member's prescription profile
        - Member is not currently being treated with another disease-modifying agent for MS
        - Member is currently being treated with another disease-modifying agent for MS **AND** the disease- modifying agent will be discontinued before starting the requested agent
    - Documentation of the following BASELINE lab reports/exams [ALL]
        - Baseline MRI [utilized to identify lesion progression (response to treatment) while on Tecfidera therapy]
        - Member does not have a low lymphocyte count as documented by a recent (within 6 months) Complete Blood Count (CBC) prior to initiating therapy.
            - ***NOTE****: Further CBC monitoring is recommended at least annually during therapy or as clinically necessary (based on signs and symptoms of infection).*
- ❒ **Quantity:**
    - **Tecfidera Starter Kit**: ONE time authorization of a 30-day supply only
    - **Tecfidera 120mg delayed release capsules**: 14 capsules (starting dose; one time fill)
    - **Tecfidera 240mg delayed release capsules**: 60 capsules per 30 days (maintenance dose)
- ❒ **Age:** Must be greater than 18 years of age
- ❒ **Gender:** Male or Female
- ❒ **Route of Administration:** Oral
- ❒ **Place of Service:** Outpatient

Criteria for continuation of therapy:

- ❑ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Confirmation of **ONE** of the following from the Prescriber **AND** by verifying in member's prescription profile
        - Member is not currently being treated with another disease-modifying agent for MS
        - Member is currently being treated with another disease-modifying agent for MS **AND** the disease- modifying agent will be discontinued before starting the requested agent
    - **Adherence to Therapy**
        - Member compliance with therapy as verified by Prescriber and member's medication fill history (review prescription history for compliance)
            - ***NOTE:*** *Therapy may be discontinued due to compliance issues or poor adherence upon agreement among treating physician, member, and Medical Director.*
    - **Labs/Reports/Documentation required [ALL]**
        - Treatment with dimethyl fumarate may decrease lymphocyte counts, therefore a complete blood count should be obtained within six months of starting the medication and at least annually or as clinically indicated during the course of treatment. Dimethyl fumarate has not been studied in patient with pre-existing low lymphocyte counts.

Criteria for continuation of therapy

- ❒ **Documentation Requirements, continued**
  - Stabilization or positive response to Tecfidera® (dimethyl fumarate) treatment. Demonstrated efficacy as evidenced by (including but not limited to the following): **[ALL APPLICABLE]**
    - **Relapses:** A decrease in frequency, severity, sequelae relapses from baseline
    - **Radiologic evidence of disease activity:** Beneficial effect on MRI measures of disease severity (decrease in number or volume of gadolinium-enhancing lesions, T2 hyperintense lesions and/or T1 hypointense lesions)
  - **Disability progression:** EDSS score remains less than or equal to 5.5 or stabilization/improvement routine neurological observation, mobility, or ability to perform activities of daily living
  - Validated patient reported outcome measure [i.e. Fatigue Impact Scale (FIS), Medical Outcome Study SF-36, etc]
    - *Fatigue Impact Scale (FIS) is a validated patient reported outcome measure that evaluates the effect of fatigue on the lives of people with MS. The Medical Outcome Study SF-36 is a self-administered health-reported quality of life outcome measure that is validated for several indications and patient populations*

Contraindications/Exclusions/Discontinuation:

- Steady progression of disability
- Drug toxicity or serious adverse reaction
- Non-FDA approved indications
- Authorization will not be granted if ANY of the following Contraindications/Exclusions to Tecfidera® (dimethyl fumarate) therapy apply**:**
  - Hypersensitivity to Tecfidera® (dimethyl fumarate) or any ingredient in the formulation
  - History of significant gastrointestinal (GI) disease, chronic use of GI symptomatic therapy
  - Active malignancies
  - **NOTE:** "Needle phobia" or "needle fatigue" is not considered a contraindication.
- Concomitant therapy of any two disease modifying agents in MS
- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- For use as monotherapy therapy only:
  - Prescriber intends to use Tecfidera® (dimethyl fumarate) as a single agent; no other disease-modifying multiple sclerosis medications are being administered concomitantly, including but not limited to: interferon beta-1a (Avonex®, Rebif®), interferon beta-1b (Betaseron®, Extavia®), glatiramer acetate (Copaxone®), mitoxantrone (Novantrone®), natalizumab (Tysabri®), fingolimod (Gilenya™), teriflunomide (Aubagio®)

TEKTURNA® / ALISKIREN
TEKTURNA HCT® / ALISKIREN-HYDROCHLOROTHIAZIDE

Drug Class: Renin Inhibitor, Direct

FDA-approved uses: For the treatment of hypertension either as monotherapy or in combination with other antihypertensive agents

Available dosage forms:

- ❒ Tekturna Tablets 150 mg and 300 mg
- ❒ Tekturna HCT Tablets 150-12.5 mg, 150-25 mg, 300-12.5 mg and 300-25 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Mild to moderate hypertension
- ❒ **Duration of Approval:**
  - **Initial Approval:** 3 months
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Documentation of trial and failure of previous therapies (Technician review of relevant patient fill history)
  - Must have tried and failed two drug combinations
    - Failed/intolerant to thiazide diuretics
    - Failed/intolerant to ACE inhibitors
    - Failed/intolerant to ARBs
    - Failed/intolerant to beta blockers
    - Failed/intolerant to calcium channel blockers
- ❒ **Quantity:** #30 per month
- ❒ **Age**: Adults. Safety and efficacy has not been determined for adolescents and children
- ❒ **Route of Administration:** Oral

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Member currently meets **ALL** initial coverage criteria

Criteria for continuation of therapy:

- ❒ **Documentation Requirements, continued** (e.g. Labs, Medical Record, Special Studies):
  - Compliance:
    - Adherence to therapy at least 85% of the time as verified by Prescriber and member's medication fill history (review Rx history for compliance), including:
      - Compliance in taking the medication as prescribed
      - No intolerable adverse effects or drug toxicity
        NOTE: *Therapy may be discontinued due to poor adherence upon recommendation of the Medical Director when adherence < 85% has been demonstrated in at least two months during the course of therapy*
  - Labs/Reports/Documentation required:
    - Maintenance therapy may be authorized when therapy has demonstrated efficacy as evidenced by an improvement in disease activity after initial therapy. Documentation of disease stabilization or improvement is required for continuation of therapy

Contraindications/Exclusions/Discontinuation:

- Discontinuation of Treatment [**ANY**]
  - Poor response to treatment as evidenced by physical findings and/or clinical symptoms following the initial 12 weeks approval for coverage
  - Intolerable adverse effects or drug toxicity
  - Persistent and uncorrectable problems with adherence to treatment
  - Drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Adverse Effects:
  - A concern is hypotension that is not reversed when the drug is stopped due to the strong binding of renin and the long half-life of aliskiren (24-30 hrs).
  - Aliskiren still is detectable in the kidneys up to 3 weeks after discontinuation.
  - Doses greater than 300mg did not give an increased blood pressure response but increased the rate of diarrhea.
  - Rate of cough was 1.1%, which was about one-half to one-third the rate of cough seen with ACE inhibitors.
  - Two cases of angioedema with respiratory symptoms and two cases of periorbital edema without respiratory symptoms were noted. Therefore angioedema occurred in 0.06% of patients.
  - Increases in potassium were uncommon (0.9% compared with 0.6% with placebo). However the rate of hyperkalemia is expected to be greater if aliskiren is combined with an ACE inhibitor.

<u>Other special considerations</u>, continued:

- Cautions:
    - Experience with the use of aliskiren in patients with severe renal impairment is limited and therefore, caution is warranted. It does not appear to have an effect on serum creatinine, but data is lacking to confirm this.
- Indications:
    - The majority of trials included patients with mild to moderate hypertension.
    - Limited data suggest that aliskiren also could be safe in severe hypertension as part of a combination therapy strategy.
- Efficacy:
    - Overall data from studies show aliskiren to be superior to placebo and similar or better efficacy compared with other commonly used agents.
    - Aliskiren directly inhibits rennin while other antihypertensives target the rennin-angiotensin system.
    - Has not been studied with maximal dose of ACE inhibitors.
    - Modestly lowers blood pressure when used as monotherapy and has shown to have additive effects when combined with a thiazide diuretic or an ARB.
    - Aliskiren has not been shown to improve clinical outcomes as seen with ACE inhibitors and ARB's in heart failure, coronary artery disease and renal disease therefore should only be used for hypertension at this time

TEMOVATE® / CLOBETASOL

Drug Class: Dermatological – Glucocorticoid (Super High Potency)

FDA-approved uses: The relief of inflammatory and pruritic manifestations of corticosteroid-responsive dermatoses.

Available dosage forms: 0.05% Cream, Ointment and Solution

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Inflammatory/Pruritic corticosteroid-responsive dermatoses
- ❒ **Documentation Requirements**: (e.g. Labs, Medical Record, Special Studies):
  - Tried and failed Betamethasone Dipropionate
- ❒ **Quantity:** 15gm-60gm depending on size of affected area
- ❒ **Age:** 12 years of age and older
- ❒ **Route of Administration:** For Topical Use Only

Contraindications/Exclusions/Discontinuation:

- Therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

TOBI®- GENERIC AND TOBI® PODHALER™ / TOBRAMYCIN

Drug Class: Aminoglycoside Antibiotic

FDA-approved uses: The management of Pseudomonas aeruginosa in patients with cystic fibrosis

Available dosage forms:

- ❒ **Solution for Inhalation:** TOBI® for inhalation: 300 mg/5ml single use ampule for nebulization
- ❒ **Powder for Inhalation:** TOBI® Podhaler™ 28mg capsules (use in Podhaler™ device TOBI® and TOBI® Podhaler™)

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Cystic fibrosis
- ❒ **Duration of Approval:**
  - **Initial Approval:** 6 months
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:** Pediatrician or Infectious Disease specialist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Suspected or confirmed diagnosis of *Pseudomonas aeruginosa* lung infection
  - FEV_1 between 25-75% predicted (Tobi® Podhaler™, tobramycin inhalation solution)
- ❒ **Quantity:** 28 day supply every 56 days (28 days on, 28 days off)
- ❒ **Age:** 6 years of age and older
- ❒ **Route of Administration:** Inhalation

TOBI® Podhaler™

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** Cystic fibrosis
- ❒ **Duration of Approval:**
  - **Initial Approval:** 6 months
  - **Continuation of Therapy:** 1 year
- ❒ **Prescriber Specialty:** Pediatrician or Infectious Disease specialist
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Suspected or confirmed diagnosis of *Pseudomonas aeruginosa* lung infection
  - FEV_1 between 25-75% predicted (Tobi Podhaler, tobramycin inhalation solution)
  - Patient has tried and failed tobramycin inhalation solution (generic TOBI®)
- ❒ **Quantity:** 28 day supply every 56 days (28 days on, 28 days off)
- ❒ **Age:** 6 years of age and older
- ❒ **Route of Administration:** Inhalation

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
    - Confirmation that the member continues to have a beneficial response to therapy as assessed and documented by the member's provider

Contraindications/Exclusions/Discontinuation:

- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.
- Allergy to tobramycin or other aminoglycosides

ULORIC® / FEBUXOSTAT

Drug Class: Hyperuricemia Therapy - Xanthine Oxidase Inhibitors

FDA-approved uses: gout prophylaxis

Available dosage forms: Tablets 40 mg and 80 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses**: Chronic management of hyperuricemia in patients with gout
- ❒ **Duration of Approval:**
  - **Initial Approval:** 3 months
  - **Continuation of Therapy:** 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Must have documented evidence of gout with hyperuricemia
  - Must have tried and failed or intolerant to gout-hyperuricemia treatment with another xanthine oxidase inhibitor (allopurinol)
  - Documentation of adequate trial and failure of preferred formulary agent or contraindication to preferred formulary agent
  - 80 mg tablets require documentation that serum uric acid levels 2 weeks following initiation of therapy is greater than 6 mg/dL
- ❒ **Quantity**: 30 tablets per 30 days (40mg or 80mg tablet once daily)
- ❒ **Age**: Must be greater than 18 years of age
- ❒ **Gender:** Male or Female
- ❒ **Route of Administration:** Oral
- ❒ **Place of Service:** Outpatient

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - A demonstrable decrease or cessation in gouty flares
  - A serum uric acid level less than 6 mg/dL following 2 weeks of therapy **OR**
  - A serum uric acid level greater than 6 mg/dL following 2 weeks of therapy at 40 mg daily dosing with the intent to increase to the maximum dosing of 80 mg daily

Contraindications/Exclusions/Discontinuation:

- Excluded for the treatment of asymptomatic hyperuricemia
- Contraindicated in patients being treated with azathioprine or mercaptopurine
- Not approved in conditions where urate levels are greatly increased due to malignancy
- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Caution in patients with severe hepatic impairment (Child-Pugh Class C)
- Caution in patients with severe renal impairment (CrCl less than 30 mL/min)

VALCYTE® / VALGANCICLOVIR

Drug Class: CMV Antiviral Agent – Nucleotide Analogs

FDA-approved uses: VALCYTE is a cytomegalovirus (CMV) nucleoside analogue DNA polymerase inhibitor indicated for:

- ❒ **Adult Patients**
  - Treatment of CMV retinitis in patients with acquired immunodeficiency syndrome (AIDS).
  - Prevention of CMV disease in kidney, heart, and kidney-pancreas transplant patients at high risk.
- ❒ **Pediatric Patients**
  - Prevention of CMV disease in kidney and heart transplant patients at high risk.

Available dosage forms: Tablets- 450 mg, Oral Solution- 50 mg per mL

Coverage Criteria/Limitations for initial authorization

- ❒ **Diagnoses:**
  - Cytomegalovirus (CMV) retinitis in HIV-infected patient
  - CMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney
- ❒ **Duration of Approval:**
  - **Initial Approval**: 1 year
  - **Continuation of Therapy**: 1 year
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Cytomegalovirus (CMV) retinitis in HIV-infected patient **AND**
    - Documented use in combination with Vitrasert (ganciclovir intraocular implant); **OR**
  - CMV infection prophylaxis for those at high risk of CMV disease following transplantation of the heart, kidney-pancreas, or kidney

Criteria for continuation of therapy:

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Patient tolerating and responding to treatment

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to valganciclovir or ganciclovir
- patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

VICTOZA® / LIRAGLUTIDE

Drug Class: Antihyperglycemic – Incretin Mimetic, GLP-1 Receptor Agonist Analog

FDA-approved uses: Type 2 diabetes mellitus: Indicated as adjuvant therapy to improve glycemic control in patients with Type 2 diabetes mellitus

Available dosage forms: Subcutaneous Injection 18 mg/3ml

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA Approved Indication as listed above
- ❒ **Duration of Approval**
  - **Initial Approval:** 6 months
  - **Continuation of Therapy:** 6 months
- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Trial, failure or intolerance to at least two (2) antidiabetic agents such as:
    - metformin
    - sulfonylurea
    - TZD
    - DPP-4 Inhibitor
    - SGLT-2 inhibitor, **OR**
    - insulin and has not achieved adequate glycemic control (HbA1c > 7% after 3 continuous months of receiving maximal daily doses) despite current treatment
  - Chart notes confirming all previous antidiabetic therapy; medications tried, dates of trial, response to therapy.
  - A1c lab < 10%.
- ❒ **Age:** ≥ 18 years of age

Criteria for continuation of therapy:

- ❒ **Documentation Requirements (e.g. Labs, Medical Record, Special Studies):**
  - Patient tolerating and responding to treatment

Contraindications/Exclusions/Discontinuation:

- Not approved for convenience or if noncompliant with therapies
- HbA1c < 7.0%
- Type 1 diabetes
- Hypersensitivity or contraindications to the use of liraglutide
- Presence of medullary thyroid carcinoma; personal or family history
- Presence of multiple endocrine neoplasia syndrome type2
- Excluded if primarily being used for weight loss

Contraindications/Exclusions/Discontinuation, continued:

- **Boxed Warning: Thyroid C-cell tumor risk:**
  Liraglutide causes dose-dependent and treatment duration–dependent thyroid C-cell tumors at clinically relevant exposures in both genders of rats and mice. It is unknown whether liraglutide causes thyroid C-cell tumors, including medullary thyroid carcinoma (MTC), in humans, because the human relevance of liraglutide-induced rodent thyroid C-cell tumors has not been determined.
  Liraglutide is contraindicated in patients with a personal or family history of MTC and in patients with multiple endocrine neoplasia syndrome type 2 (MEN 2). Counsel patients regarding the potential risk for MTC with the use of liraglutide and inform them of symptoms of thyroid tumors (e.g., a mass in the neck, dysphagia, dyspnea, persistent hoarseness). Routine monitoring of serum calcitonin or using thyroid ultrasound is of uncertain value for early detection of MTC in patients treated with liraglutide.
- In addition, drug therapy may be discontinued if patient is noncompliant with medical or pharmacologic therapy **OR** no demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- FDA has determined that a Risk Evaluation and Mitigation Strategy (REMS) is necessary to ensure that the benefits of Victoza outweigh the potential risk of medullary thyroid carcinoma and the risk of acute pancreatitis http://www.victozapro.com/rems-program.aspx
- Prescriber requirements: Prescribers are encouraged to review the Dear healthcare Provider letter that provides safety information and prescribing recommendations for liraglutide: http://www.fda.gov/downloads/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/UCM202063.pdf.

XARELTO® / RIVAROXABAN

Drug Class: Direct Factor Xa Inhibitors

FDA-approved uses:

- ❒ Reduce the risk of stroke and systemic embolism in patients with non-valvular atrial fibrillation.
- ❒ DVT prophylaxis in patient undergoing knee or hip replacement surgery
- ❒ For the treatment of DVT, pulmonary embolism (PE) and for the reduction in the risk of recurrence of DVT and of PE.

Available dosage forms: Tablets 10 mg, 15 mg and 20 mg

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA-approved uses as listed above
- ❒ **Duration of therapy**:
  - **Initial Approval:** 3 months
  - **Continuation of Therapy:** 1 year for stroke prevention in A-fib and DVT prophylaxis
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - **Patient was started on Xarelto therapy in the hospital and was discharged while on the therapy**
  - **Criteria for use for stroke prevention in A-fib:**
    - Patient has diagnosis of non-valvular atrial fibrillation
    - Must have tried and failed **or** intolerant to warfarin therapy
    - Must have moderate to high risk for stroke as determined by the following:
      - Either history of stroke, TIA, or systemic embolism **OR**
      - **TWO** of the following:
        - heart failure or LVEF ≤ 35%
        - HTN
        - ≥75 years old **or**
        - diabetes mellitus
  - **Criteria for use for treatment of DVT or PE:**
    - Must have DVT or PE
    - Must have tried and failed or intolerant to warfarin therapy
  - **Criteria for use for DVT prophylaxis after knee or hip replacement surgery:**
    - Must have undergone elective total hip arthroplasty or total knee arthroplasty
- ❒ **Quantity/Duration**: According to FDA-approved use
  - **Non-valvular atrial fibrillation**: to be determined by the prescriber
  - **DVT prophylaxis:**
    - **Hip Replacement surgery**:35 days recommended
    - **Knee replacement surgery**: 12 days recommended
  - **Treatment of DVT and PE**: to be determined by prescriber
- ❒ **Age:** > 18 years of age

Criteria for continuation of therapy:

- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Patient is tolerating and responding to medication and there continues to be a medical need for the medication.
  - CrCL is being monitored

Contraindications/Exclusions/Discontinuation:

- **Box Warning** :
  - Discontinuing Xarelto can lead to higher risk of stroke. If discontinuation is warranted for reasons other than pathological bleeding, consider use of another anticoagulation agent.
  - Administration of Xarelto while also receiving neuraxial anesthesia or undergoing spinal puncture can lead to epidural or spinal hematomas, which can result in long term or permanent paralysis.
  - If discontinuation is warranted due to risk of bleeding with surgery or other procedures, temporarily stop Xarelto at least 24 hours before procedure. Restart after the procedure once adequate hemostasis has been established.
  - Avoid in CrCl < 15 ml/min
  - Avoid use with P-gp and strong CYP3A4 inhibitors/inducers.
- Active pathological bleeding
- Hypersensitivity reaction to Xarelto
- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- No specific antidote is available

ZYVOX® / LINEZOLID

Drug Class: Oxazolidinone Antibiotic

FDA-approved uses:

- ❒ **Pneumonia:**
  - **Community-acquired:** Treatment of community-acquired pneumonia caused by Streptococcus pneumoniae, including cases with concurrent bacteremia, or Staphylococcus aureus (methicillin-susceptible isolates only).
  - **Hospital-acquired or healthcare-associated:** Treatment of hospital-acquired or healthcare-associated pneumonia caused by *S. aureus* (methicillin-susceptible and -resistant isolates), or *S. pneumoniae*
- ❒ **Skin and skin structure infections:**
  - **Complicated:** Treatment of complicated skin and skin structure infections, including diabetic foot infections, without concomitant osteomyelitis, caused by *S. aureus* (methicillin-susceptible and -resistant isolates), *Streptococcus pyogenes*, or *Streptococcus agalactiae*.
  - **Uncomplicated:** Treatment of uncomplicated skin and skin structure infections caused by *S. aureus* (methicillin-susceptible isolates) or *S. pyogenes*.
- ❒ **Vancomycin-resistant enterococcal infections:** Treatment of vancomycin-resistant *Enterococcus faecium* (VRE) infections, including cases with concurrent bacteremia.[1]

- ❒ **Limitations of use:** Linezolid has not been studied in the treatment of decubitus ulcers. Linezolid is not indicated for treatment of Gram-negative infections; if a concomitant Gram-negative pathogen is documented or suspected, initiate specific therapy immediately

- ❒ **Off-label uses:**
  - Brain abscess, subdural empyema, spinal epidural abscess (*S. aureus* [methicillin-resistant])
  - Infective endocarditis
  - Infective endocarditis (adults)
  - Infective endocarditis (children/adolescents)
  - Meningitis (*S. aureus* [methicillin-resistant])
  - Osteomyelitis (*S. aureus* [methicillin-resistant])
  - Prosthetic joint infection
  - Septic arthritis (*S. aureus* [methicillin-resistant])
  - Septic thrombosis of cavernous or dural venous sinus (*S. aureus* [methicillin-resistant])

Available dosage forms: *Tablet 600 mg, *Oral Suspension 100 mg/5ml, IV Solution 2 mg/ml
Covered on the Managed Care Common Formulary

Coverage Criteria/Limitations for initial authorization:

- ❒ **Diagnoses:** FDA approved indications above
- ❒ **Prescriber Specialty:** Infectious Disease (ID) consult that recommends Zyvox
- ❒ **Documentation Requirements** (e.g. Labs, Medical Record, Special Studies):
  - Must include culture and sensitivity that is susceptible to linezolid
  - Diagnosis supported by any applicable labs and/or tests as evidenced by patient's medical record

- ❒ **Quantity:**
  - 14 days (dosed every 12 hours) or
  - 28 days for VRE

    OR
  - ID recommends that a longer course of therapy is required
- ❒ **Route of Administration:** oral

Contraindications/Exclusions/Discontinuation:

- Hypersensitivity to linezolid or any component of the formulation
- Concurrent use or within 2 weeks of monoamine oxidase inhibitors (MAOIs)
- Patient is noncompliant with medical or pharmacologic therapy
- No demonstrable clinically significant improvement in condition has occurred after initiation of drug therapy.

Other special considerations:

- Patient has a severe allergy to antibiotic to which the organism is susceptible

  OR
- Patient has failed treatment with antibiotic to which the organism is susceptible